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Place, Need and Precarity in UK Mental Health Care:  
An Ethnography of Access

Natassia Ford Brenman

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Faculty of Public Health and Policy  
London School of Hygiene and Tropical Medicine



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‘I, Natassia Ford Brenman, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.’

## Abstract

In this thesis, I investigate the co-production of “place” and “need” in voluntary sector mental health care, in order to re-think and breathe new life into the problem of access to services. The research draws on ethnographic fieldwork from 2016-2018 at three psychotherapy centres providing different specialised services in London. I describe how, in these places, the visibility of the “vulnerable migrant” client group, and notions of culturally specific need, reflects a global—but perhaps temporary—“turn” to migration. I attend to the everyday practices of care providers working to “fill gaps” in mainstream service provision, and tell fragments of client stories about *moments of access* at each site. Drawing on data generated from interviews, observations and a creative method, I describe practices around the sociomaterial thresholds and doors to each service: waiting, accessing, assessing, gate keeping, and including or excluding. Part One, on “Place,” makes visible a paradox, whereby the work to create and maintain inclusive places for people who may not “belong” elsewhere in the mental health system, (re)produces the precarity of both people and places, positioned “always *almost* on the outside.” Part Two, on “Need,” extends this inquiry into boundary work and precarity, showing how working against mainstream classifications of need created possibilities but came at a cost. To produce eligibility and access to care, providers made mental health need *legible* through laborious negotiation between funders, their internal values and interests, and wider matters of concern. The ordering of these two parts builds the argument, grounded in theories of relationality and milieu, that places are not merely inert “context” but are generative of certain forms of need. The chapters in this thesis move away from seeing care providers as “solutions” to “unmet need,” opening up new problem spaces around the practice of *doing need differently*.

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**Image 1: Waiting (photograph by the author)**

## Chapter 1: Assembling the problem of access

I follow the instructions of the word-processed sign reading “By appointment only, please use the bell to enter,” pressing the small white button and waiting for the buzz and the click of door giving in to the pressure of my other hand. The façade of the building is tiny, squashed in between local shops; on one side there’s an express supermarket, and on the other, a Lebanese café, whose tables and chairs spill out to the pavement in front of the therapy centre. The space I walk into counters the busy outside with its solid stillness. A small sequined wall-hanging catches my eye on the left, interrupting the series of doors lining the long corridor ahead. There is no reception desk, but in the doorway of the office, immediately on the right, hovers a woman who takes my name and enquires about whom I would like to see. The exchange of names and information is done standing in the corridor before I am guided to a small waiting room, where I sit down next to an overflowing notice board on one of several inwards-facing chairs.

This moment, in many ways, was utterly unremarkable. And yet, it was the beginning of something. It was the first time I encountered the therapy centre that would become one of three field sites I would engage with intensively over the next eighteen months; entering and leaving through this door, and others like it, so often that they would quickly begin to disappear from view. Was this the moment I “accessed the field”? Or was it when I was told about the centre by a local mental health service provider, who said I should look them up— that they might be able to tell me something about so-called “hard to reach groups” in the area? Perhaps it was the moment when I sat down with clinical manager and director (who briefly occupied the role of “gatekeepers” to the visiting ethnographer) to establish shared concerns and interests that we might start building a project around. Maybe it was several years before this, when I myself began working in non-governmental organisations and on projects to improve access to services in the field of global mental health. I draw upon this particular moment of research “access” only fleetingly, in order to pinpoint a moment in time and (crucially for me) *in place*, that I can call a beginning.

In this thesis, I orient my analysis towards such *moments of access*, as they are enacted by those who encounter and deliver mental health services in an inner city area of

London in the UK. I focus specifically on services on the peripheries of the mainstream health and social care system, in what is referred to in this context as the voluntary, or sometimes, the “third” sector. The beginnings I am interested in are those that mark people’s points of access into psychotherapeutic care. The moments in which they walk through the doors of a clinic can of course also be seen as arbitrary (just one in a series of many possible beginnings) but I argue that we can learn from analysing these moments in place, foregrounding their social and material context. Moreover, I argue that place is not ‘just’ context, but rather, it is generative and poses its own problems. This ethnographic orientation towards access as *moments in place* makes a break with mainstream analyses in public health research, which tends to frame “access” in far more generalised, abstract terms such as “pathways,” “barriers” and “facilitators.” And so, before I begin to unpack this methodological and disciplinary orientation in the chapters that follow, I want to take a look at some of these ideas that I am claiming to make a break with. In doing so, I hope to raise some of my concerns about their underlying assumptions.

“Access” has emerged within public health as an *object*, as well as an *objective*: specifically, a key “priority for change” in the field of mental health (Independent Mental Health Task Force 2015). Access to mental health care, and healthcare in general, is often framed as something absolute, yet somewhat elusive, which you either “have” or you “don’t have.” It is a goal, something positive, and it is associated with inclusion and equality— public “goods” in themselves. Yet, as long as inequalities, resource shortages and unmet need exist, “access” denotes a *problem* more than it does a *good*. The persistence of vast inequity and discontent with levels of access to (mental) health care in a high-income country such as the UK, with a “free at the point of access” model of healthcare, is testament to this. Perhaps it is more accurate to speak of this public health object as a “problem” of access, rather than of access itself. *Yet still*, one would be hard-pressed to pin down any one problem as this object. For me, this is to be confronted with a huge set of practices, shaped by the values and infrastructure our healthcare system, as well as the ever-changing communities it serves; it is to be confronted with fundamental questions of what we are providing access *to* and whom it is *for*; what kind of disorder, distress or suffering

constitutes a *need* for professional intervention; and who remains excluded and invisible, no matter how hard we try to see them and the “gaps” they leave.<sup>1</sup>

These are some of the messy complexities I try to keep in view within my ethnography of access, but they do not fit easily into the “problem-solution” models of public health and mainstream psychological services. In this general introduction I intend to produce something of a “snapshot” of how this problem of access is currently assembled in the field of UK mental health care. In following these lines of problematisation I seek to raise questions about what they might be foreclosing. It is from here that I begin to think about how this problem might be *reassembled*, in the chapters that follow: how it might encompass the processual, situated, material, spatial, human and non-human entities that make up access; perhaps as a different kind of problem, which is less static and more responsive to the ever-moving landscape of mental health and care.

### **Accessing “the mainstream” in mental health care**

This ethnography tells a story of three separate but interconnected psychotherapy “counter-clinics,” as anthropologist Elizabeth Anne Davis (2018) might describe them.<sup>2</sup> By this, I mean that they are non-state services, situated always *in relation* to a mainstream. Whether these relations make them entirely “counter” to mainstream mental health care, and/or mutually dependent on it, is a question that I grapple with in various ways throughout the thesis. In any case, it is necessary to lay out what these centres ran counter *to*, within the current system of psychotherapeutic service provision. The national programme, which has defined mainstream psychotherapy in England for the last fifteen years, is called Improving Access to Psychological Therapies, commonly known as IAPT. As the name suggests, “access” is at the heart of this project and the logics underlying it. The “psychological therapies” part of it

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<sup>1</sup> The vocabulary of “treatment gaps” is now ubiquitous in the global mental health literature of access to mental health care, and has been adopted in national policy-making discourse (Farmer 2015; Patel et al. 2010)

<sup>2</sup> This notion of “counter clinics” has been put forward by Elizabeth Anne Davis (2018) in her introduction to the recent special issue on this theme in *Medical Anthropology*, referring to “politicized and otherwise ‘alternative’ clinics” in mental health (*ibid*, 6), which I discuss in Chapter 2 of this thesis.

reflects a renewed public interest in talking therapy, amidst grave concerns about the over-diagnosis and medication of common mental disorders in the age of “big-pharma.” I explore some of the historical antecedents to this programme, and its relationship to psychiatry, in the Interlude, mid-way through the data chapters of this thesis. Here, however, I seek to briefly shine a light on the particular logics of this mainstream project of “improving access” to psychotherapeutic care.

The rationale for IAPT is usually presented through evidence of clinical need within the general population, maintaining an assumption that this need pre-exists services and is “out there” waiting to be met. This is not to say that there is an expectation that *all* needs can be met by this programme; at its heart, IAPT is highly pragmatic and aims to identify and treat only common mental disorders. These are depression and anxiety disorders, of a certain level of severity, measured by their “cluster level,” within a clinical guideline of assessing need. Crucially, the treatment (the vast majority of which involves cognitive behavioural therapy, though not exclusively) is evidence-based, and so the logic is that it will only work for this level and kind of need. Without entering into the extensive debates that have ensued since this was rolled out in 2008, about the validity and accuracy of measuring what “works” when it comes to psychotherapy, it is important to know that IAPT rests on principles of measurability, universalism, and national standards. In all these ways IAPT lives up to its role as “the mainstream” to the smaller, locally oriented projects, which this piece of research centres around. Crucially, however, these qualities do not make this project politically neutral, nor disconnected from the particular climate of austerity politics that was at its height when I started this project, and which I touch upon in some more detail below.<sup>3</sup> The assumption that need exists “out there,” to be measured and then met by services serves a pragmatic function but it forecloses questions about the contexts and value systems in which need is understood, articulated, and mobilised. My job as an ethnographer is to ask these questions, and to understand what need *does* in relation to access, rather than to measure or define what it *is*.

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<sup>3</sup> Critics such as Greco and Stenner (2013) have made direct links between the logics of IAPT and those of austerity politics and the decline of the welfare state, with these authors describing “an emphasis on individual duties and responsibilities...in a context where the mechanisms previously designed to provide a safety net against social ills are being progressively dismantled” (ibid., 10).

## Filling “gaps” in austerity Britain

Built into the logics of IAPT are ideas of coverage and completeness, but there is another, somewhat contradictory logic that has emerged within policies designed to improve access to mental health care. Echoing the core rationale for initiatives in the global mental health field, the notion of the “treatment gap” is now often a headline within UK policy documents, referring to the disparity between estimated levels of mental health need and those receiving care (Department of Health 2014a). However, this is often conflated with different kind of gap: that of a gap in service coverage, usually due to lack of resources. Particularly within the last decade, following the financial crisis and the subsequent 2010 election of a Conservative/Liberal Democrat coalition in the UK, austerity has heavily impacted the mental health care system (already a famously under-resourced area). As a result, there is an *expectation* that gaps will remain in care provision and that they must be filled by alternative means. Looking into this gap,<sup>4</sup> we see that the voluntary sector has been positioned as a vital source of service provision in the UK: “a shock absorber in a time of need” (Foster et al. 2015). This is an impactful statement, which speaks volumes about the role of the voluntary sector at this time, but I want to continue gently challenging the assumptions that underlie it: do places and services really just “absorb” need? Or do they play a more active role in this story of access?

What I have been describing here are general and inevitable shortcomings of mental health care in an era of austerity. These conditions are pertinent to my research because the centres I was engaged with were positioned precisely in this position of “shock absorbers.” But their concern, and the concern I take interest in, is not just the *general* unmet mental health need, but forms of need associated with particular “client groups,” as they are known in the field. Crucially, these services articulate and respond to these different forms of need in ways that the mainstream is not willing or able to do. I do not study a particular “client group,” but I am interested in the role and visibility of these categories in particular spaces. For example, what emerges in

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<sup>4</sup> As Bartlett, Garriott and Raikhel (2014) have asked the global mental health field, “what’s in the treatment gap?”

my research is the sense of urgency and traction in responding to the needs of migrant and refugee communities. This has become particularly visible since the migrant “crisis” (as it became known in the media) in Europe and the way in which this has filtered into national politics. In the UK’s current political climate, London’s super-diverse<sup>5</sup> population has been confronted with infamous “hostile environment” policies (Consterdine 2018). Restrictions in access to appropriate care for migrants (and ethnic and cultural minorities in general) have made this particular gap in care striking and concerning to many, particularly those who resist such policies and who have been positioned to absorb their effects.

So, whether referring to general or specific gaps in a fragmenting mainstream, the current narrative (which I have been reflecting upon here) is of the voluntary sector as an underappreciated but essential “filler”, “plug” or “bridge” to fill these gaps (see, for example, Flanagan and Hancock 2010; Stern, Hard, and Rock 2015; Maudsley Debates 2010). But there is one final development, which is important to know for the context of this research: that *this too* is being formalised and built into the current system of contracting clinical services in the UK. The “any qualified provider” policy of the Health and Social Care Act (2012) deploys voluntary services to provide care to underserved and specialised groups who find it harder to access services via mainstream clinical routes. This system frames non-state actors as partners of the state (Giddens 2013; Rees, Miller, and Buckingham 2014), raising questions about the degree to which these voluntary services can run “counter” to their state counterparts. As the boundaries between voluntary and mainstream care begin to leak, it becomes harder to think about clear wholes with gaps to be filled. In the chapters that follow, these shifting inside/outside, centre/periphery, part/whole logics are explored as spatial arrangements and products of everyday practices within my small cluster of field sites.

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<sup>5</sup> The term super-diversity has been deployed in urban anthropology to describe Britain, and specifically London’s demography (Vertovec 2007; Hall 2013). These ethnographers’ work is discussed in parts II and III of Chapter 2 in this thesis.

## **Problematising mental health access: a research programme**

Before I turn, in my next chapter, to knowledge production from my own academic field, I want to briefly stay with the public health problematisation of access to mental health care. To set the scene of the research element of this construction of the problem, I look to a UK based field of research, aimed at analysing and ultimately improving access to mental health care. This work is increasingly embedded in the development of (complex) interventions aimed specifically to address the problems of limited access (e.g. Dowrick et al. 2016). And so whilst access gaps are, by their very nature, neglected areas of public health (compared to large scale evaluations of mainstream services, for example), the topic has a distinct and visible place within the health services literature. These concerns around access, coupled with the need for a research “population,” has produced programme of work that has centred around the contested term of the “hard to reach” (Mackenzie et al. 2012; Department of Health 2002). A keen self-awareness of the problems associated with categorising populations in this way has seen careful re-defining of this group in public (mental) health.<sup>6</sup> My concern is not with further critiquing the use of such terms, but rather, with questioning their underlying assumptions: that needy populations exist “out there,” to reach or be reached.

A trope that has emerged recently is that there has been too much focus on supply side factors and not enough on the demand side: an endeavour to shift attention away from services and on to the populations themselves, but one that I would argue reproduces much of the same ways of thinking about services and populations. Social scientists in this field have mobilised their expertise in gleaning the “patient perspective” focusing on their perceptions of barriers and facilitators to care, conceptualised along what is known as “pathways to care.” Work has also been done to bring these “sides” of supply and demand literature together, analysing service users’ “candidacy” and “fit” for services. This has resulted in a body of work that seems to be aiming for a complete comprehensiveness of perspectives and angles through integrative reviews and meta-ethnographies (Dixon-Woods et al. 2005,

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<sup>6</sup> Examples include “underserved” (Lovell et al. 2014; Wang et al. 2005) and “vulnerable” (Tee and Lathlean 2004; Dixon-Woods et al. 2006) and “marginalised”(O’Donnell et al. 2016).

2006; Lamb et al. 2012; Garrett, Charlotte et al. 2012). Analytic concepts are built by codifying and analysing large amounts of qualitative data in order to capture the interactions between service users and service providers in the access process (Dixon-Woods et al. 2006; Lamb et al. 2012). The irony is that that all this work to qualitatively refine, conceptualise, and operationalise “access” brings us ever further away from the practices and spaces that make up the everyday enactments of this problem. What is more, this supply and demand/barriers and facilitators approach (even as it becomes ever more sophisticated and comprehensive) *still* sees process and movement only within “pathways” to care, whilst the providers continue to be seen as static, inert absorbers of need.

### **Situating this research project: a very brief introduction to the field**

I have been critically reflecting on the ways in which the problem of access has been assembled in public health, psychological services, and health services research. I do this not to claim this research is “wrong,” and certainly not to diminish the problem of exclusions and shortcomings in mental health care provision. Rather, I do it to think carefully about what these particular formulations of the problem might be foreclosing. My concern is that the assumptions I have been laying out have meant there has been very little attention to the specific social and material contexts in which mental health care is delivered. This may be particularly true in the case of psychotherapeutic care, because the therapy centres around talk, which is often disconnected from material and spatial contexts, and embodied experiences.<sup>7</sup> My approach to knowledge production follows a rather different tradition, which assumes that practices and knowledge alike is always situated (Haraway 1988). So, without further discussion of this approach (which I leave to the chapters that follow) I turn now to my field sites.

The centre I visited briefly at the very start of this chapter was an intercultural service located in inner city London, within a short distance from my other two sites. The

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<sup>7</sup> An exception to this is the literature on “therapeutic landscapes,” which draws on psychoanalytic theory and is specifically focused on matters of space (Rose 2012; Bondi 2005a; Bondi 2005b)

centre was run for and by people from ethnic, linguistic, and cultural minorities, specialising in (but not restricted to) work with migrants and refugees. I call this service “Culture in Mind”—a pseudonym, as I use for all the services that feature in my fieldwork. Then there was the centre providing psychotherapy for women: a feminist project to include women who were otherwise excluded from these services, or at least unlikely to access them. This I call the “Pankhurst Women’s Centre,” often shortened to the “Women’s Centre” for brevity. Finally, there was the service set up not for a specific social group, nor for diagnosable condition, but for anyone struggling to cope with the loss of a loved one. I call this the “Stepping Stones Bereavement Service,” or more often, simply “Stepping Stones.” The centres were established separately: different from one another, and (crucially) different from the mainstream, both in terms of public services and traditional private psychotherapy. But of course this difference is also about sameness: they were all *doing something different*. At the core, this was about making talking therapy, of one form or another, accessible. Their work was about including people who they saw to be manifestly absent from both public (state provided) and private (paid for) psychotherapeutic consulting rooms.

To provide this snapshot of where my field sites sit within the current landscape is perhaps to start at the end of another set of much more historical stories I could tell. The three voluntary organisations that I came to work with between 2016 and 2018 all started their projects between the late 1960s and early 1980s. They were set up in response to particular perceived failings of the mainstream mental health systems of the time. These specific political and social projects that each organisation set up have taken on afterlives of their own: they occupy an established space in the landscape of charitable, non-biomedical, values-based community mental health care. Though I touch upon some of this history in the chapters that follow, I keep the specifics of each story to a minimum in order to maintain the privacy of my interlocutors. What I do hope to bring into sharp focus, however, is the ways in which these projects are constantly being remade anew, operating under new constraints, and re-aligning their work and values with emergent forms of mental health need.

In my approach to knowledge production on access, I am interested in these places of care, not as “supply side factors” but as material spaces, which are nevertheless far from static: I seek to make visible the transitory nature of voluntary centres and their changing permeability (whom they are open to, where boundaries are drawn and how they are maintained or breached). I push this idea forward through close, ethnographic work, zooming in on these places’ expanding and changing thresholds, entry points, waiting rooms, and changes of location all together, until their “objectness” is called into question altogether.<sup>8</sup> Following on from this, I try to think differently about the so-called “demand-side factors,” by interrogating notions of “need.” Rather than assuming, as we often do, that need pre-exists places and practices of care, I try to understand how need comes into being in certain forms, at specific sites. In this way, I attend to the social and material processes of inclusion and exclusion, and the articulations and enactments of need; to *reassemble* this problem we call “access.”

## **The chapters**

This first chapter has critically reflected on various problematisations of “access” in the fields of public health and psychological services. It is one of three introductory chapters, which position this piece of research contextually (1), academically (2), and methodologically (3). The data chapters of this thesis are then divided into two parts: first on Place (4, 5, and 6), and second on Need (7 and 8). The division and ordering of these parts is more than just a structure, and speaks directly to my methodology and argument, which I reflect upon in the Discussion and Conclusions (9). Below, I outline these chapters in some more detail.

In Chapter 2, I orient my work within the literature that has informed this project, grounding myself in medical anthropology, and drawing upon science and technology studies and medical sociology. As I map areas of scholarship that are pertinent to my research topic, I also bring my writing into (at times critical) contact

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<sup>8</sup> This way of thinking about objects is inspired by Lauren Berlant, who talks of them becoming “looser than they appear” and perhaps more of an “effect of interest in a thing we are trying to stabilize” (Berlant 2015).

with cultural psychiatry, migration studies and human geography. Echoing my misgivings about how we conceptualise service provision, I do not seek knowledge “gaps” to fill with my research, but rather, points of departure, provocations and “problem spaces,” (Collier and Ong 2005). In light of all of this, the chapter lands on my (re)formulation of the research problem, aims and questions. Chapter 3 is called “Placing Need: a methodology,” and forms my conceptual framing of the research, as well as a detailed account of my ethnographic practice within the project. The second section of the chapter, on “mapping and tracing,” introduces a specific creative method that I developed to understand spatial experiences of accessing psychotherapy, and which generated data that I draw upon in Part One of the thesis.

Part One (on Place) visits each field site in turn: Chapter 4, “No Dumping!” focuses on the social and material management of exteriority; Chapter 5, “Sanctuary under Siege,” draws on different modes of making and managing safe therapeutic places for migrant and non-migrant women; and Chapter 6, “Placing Precarity,” is about a place of care that is itself transitory and unstable, and how this relates to practices of inclusion and (precarious) experiences of belonging. I break away from this first part of the thesis by way of an interlude, where I engage in a reflexive piece of writing that takes me, briefly, some way from my field sites. I use this to provoke questions and provide some historical backdrop for the next two data chapters.

Part Two focuses on Need, and comprises the final two data chapters. Chapter 7, on “making diagnosis absent” takes a relational approach to understanding how mental health need is articulated by both service providers and clients. Here I explore proximity, risk and possibility in relating to one another and to an absent “mainstream.” In Chapter 8 (the final data chapter), I describe spaces of negotiation where certain forms of need are produced, with implications for eligibility and access to care. Here I make explicit how these elements of Place and Need work together, drawing on the vitalist notion of the milieu. Chapter 9, the Discussion and Conclusions, synthesises the findings from the two parts and considers the implications they have for reassembling, and rethinking, the problem of access to psychotherapeutic care.

## Chapter 2: Special services, problem spaces, and spatialised problems (a literature of “access”)

Elusive terms such as “the hard-to-reach” and other umbrella terms for marginalisation in healthcare reflect the unstable nature of these social categories. Some groups and their specific needs emerge as significant to mental health and public health discourse, whilst others recede from view at different points over time. This pattern of changing visibilities takes place in the intersecting worlds of politics, public health, and the academy, meaning that the literature produced does not simply *represent* concerns about access, in/exclusion or marginality but rather, it *names* and *gives shape* to these concerns. In this chapter, I move through different iterations of categories or “kinds” (Hacking 1995) that have become salient and visible in the research/public-health/psychiatry nexus. I start with more general debates about working with difference and the “politics of recognition” in mental health care in Part I, about “special services” and “counter clinics.” In the next part of the chapter (II), I describe the “turn” to migration and mobility in anthropological and global health discourses on access to care. I use this as a case study to argue that academic infrastructure contributes significantly to framing *migration, (mental) health, and access to care*, as coherent “matters of concern” (Latour 2004b).<sup>9</sup>As I move through this work, I illuminate the ways in which anthropologists and other critical social scientists have opened up “problem spaces,” which have relevance to my own lines of inquiry.

In the third part of the chapter (III), I seek to breathe new life into problems of access by reaching out to allied disciplines and shifting scale somewhat. This part moves away from broad narratives of globality and citizenship and into the micro-geographies and materialities of accessing care. It tells a story of convergence between several disciplines (human geography, science and technology studies, and medical sociology), which have all inspired my orientation towards analysing access as *moments in place*, as I have described it in the introduction to the thesis. This work, on the social and material contexts of care provision, informs much of my own ethnographic and theoretical approach to the project. Part IV—“from place to milieu”—introduces some theoretical ideas that I use to move between the

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<sup>9</sup> For a discussion of “matters of concern” see Latour (2004c, 2004b) and specifically on the making of global matters of concern in mental health care, Moser (2008)

ethnographic sections of the thesis. Finally, I (re)formulate my research problem in light of the literature and contextual information I have set out in this chapter, introducing my conceptual framing of this problem, which I explore more fully in the methodology chapter which follows.

## **I. Mental health care, *otherwise*: “Special services” and “counter-clinics”**

In this first part of the literature review, I look at a number of ways in which anthropology has explored, come into contact with, and intervened in psychological and psychiatric practice. In doing so, I think through what anthropology has to offer debates on inclusion, exclusion and access to care. I do this through attending to two narratives of mental health care - conceptualised and practiced “otherwise”. First, I explore debates around “special services” (Bhui and Sashidharan 2003) and then look at several ethnographic accounts of “counter clinics” (Davis 2018). I also take a section, between these, to explore what I call “counter-practice” within mainstream settings. Broadly speaking, “special services” is about care provision designed for *people or communities* characterised by difference (or, put more critically, “otherness”). “Counter practice” is about different *practices* within the constraints of the mainstream, and “counter clinics” – a phrase coined recently by Elizabeth Anne Davis (ibid.) to describe politicised and alternative services—is about *the care providers and therapists* who “do things differently” in one way or another.

This should not be read as an extensive background to the academic field of anthropology and mental health, and rather as means to set a particular scene, which I can bring into contact with other disciplinary fields in the pages that follow. I am uncomfortable with the idea that this is a “review” at all, as there is a vast and rich anthropological literature of psychology and psychiatry in Euro-American cultural contexts (Fassin 2012; Luhrmann 2011; Rose 1998; Young 1995, to name a few). However, I am primarily interested in work that deals with places and providers of care working outside or on the margins of psychiatry, making this system of knowledge and practice a vital backdrop and context to my own work, but not its focus. Similarly, whilst I acknowledge the rich literature on anthropologies of psychic,

social and psychosocial suffering (for example, Biehl 2013; Biehl, Good, and Kleinman 2007; Good et al. 2008), my interest in mental health “need” is less about what mental distress and suffering “is” than about alternative ways of knowing and enacting this need within (and in order to gain access to) specific kinds of services. And so, I draw on the large bodies of work I have just touched upon above only to the extent that it helps me to make sense of what is seen as “dominant” and “mainstream” in mental health care, and what might run counter to it.

*Special services: the politics of recognition in mental health care*

Fifteen years ago, in 2003, a debate piece was published in the British Journal of Psychiatry entitled “Should there be separate psychiatric services for ethnic minority groups?” (Bhui and Sashidharan 2003). Two eminent mental health practitioners (a psychiatric epidemiologist and medical director of a mental health trust), both from ethnic minority backgrounds, whose work focused on issues of ethnicity and psychiatric services, argued the two sides of this debate. One side formulates arguments that ethnic and cultural diversity necessitates:

“Choice and a mixed economy of care, suited to the needs of the individual and flexible enough to accommodate difference.”

The other side criticises such thinking, which:

“Prioritises race or cultural difference over ethnic inequalities and, as a result, advocates culturally specific service solutions rather than striving for equality in service provision.”

As it is a short debate piece in a medical journal, the reference list is short, and located firmly within policy and the field of psychiatry. But within the text, there are many themes and issues that anthropologists have puzzled over for a long time: about psychiatry’s role in the production of difference, but also its capacity to accommodate and embrace difference; the relationship between cultural difference and ethnic inequality; the way the afterlives of colonial histories can be at once recapitulated and challenged in efforts to create progress within this arena of research and practice. There are, I think, two reasons why anthropologists (still) have so much to say about the issues raised in this BJP article; one is that the dilemma they refer to (about how to work with and represent difference) is of primary concern to medical anthropologists, and another is that there has been significant overlap between the fields, for example within the sub-field of transcultural psychiatry, which I describe

below. Far from using this paper to suggest resolutions to this discussion, I treat it as a spring board to draw out some of this anthropological attention and persistent problems around who gets access to what services, and the politics of “difference” and “specialness” in institutional contexts. This can therefore be read as a case study that I use to explore higher-level questions and to describe a historically situated debate.

The argument, from Kam Bhui, that there *should* be separate, specialised services for ethnic minority groups rests on both epidemiological and health services research that black and minority ethnic (BME) groups have worse experiences of mental health services in the UK than their white counterparts. He refers to a largely UK-based literature that can be found on access and pathways to care (Sass et al. 2009; Bhui et al. 2014), as well as the quality and acceptability of services to people because of their cultural background and the cultural contingency of psychotherapy (Bhugra and Bhui 1998; Kareem and Littlewood 2000). This body of work also reveals the persistent, disproportionately high rates of involuntary detention of people from black and minority ethnic groups with mental health problems, compared to their white counterparts (Audini and Lelliott 2002; Morgan et al. 2004). These are complex and urgent topics, which continue to generate critical work, but at this point it is worth pausing to contextualise how these issues have been made visible and how this category of difference has been employed in a particular context.

The discussion centres on a “form of alterity,” as Laurence Kirmayer calls it, applying philosopher Charles Taylor’s (1992) ideas on the “politics of recognition” in multicultural health care (Kirmayer 2011). The politics of recognition is a key concern in the field of transcultural psychiatry: a global field of research and practice concerned with social and cultural determinants of psychopathology and psychosocial treatment of disorders. It is a discipline that gets put into practice slightly differently in different contexts. In the UK, a tradition of postcolonial scholarship has developed around the negative effects of categorising people according to race, but also acknowledging race and institutional racism as powerful organising features of the mental health system (Littlewood 1990; Lipsedge and Littlewood 2005). The 1980s saw momentum to establish explicitly ‘anti-racist’ projects and clinics in non-mainstream, often voluntary sector, settings driven largely

by notions of political Blackness (Kareem and Littlewood 2000; Fernando 2005; Bourne, 2016). More recently, the acronym “BME” for Black and Minority Ethnic has been adopted in a somewhat clumsy meeting of these politicised narratives and a more sanitised public health-speak.<sup>10</sup> This composite category has become meaningful in advocacy work for improving access to services that are sensitive to cultural and racial issues, as well as an organising principle for research on multi- or transcultural healthcare.

The *problem* with this culture and ethnicity-based politics of recognition, says Sashidharan in the debate piece, is that “we almost immediately think about ‘separate,’ ‘different’ and ‘them’ requiring ‘special’ attention, outside of the mainstream... the emphasis on ‘differences’ between White and non-White continues to be a major preoccupation within Europe” (Bhui and Sashidharan 2003, 11). In other words, attention to difference between groups undermines a potentially more urgent need to attend to equality. The contention this debate raises between *values of equality* and *values of diversity and difference* is not unlike Fassin and Rechtman’s (2005) genealogical account of French mental health. They reveal a paradox in the very different values that are held up in parallel to each other (values of both universalism and culturalism). One practical similarity between what they observe in the French context and the UK context is that attention to difference and diversity is often located outside mainstream or state-funded systems of care (Fernando 2005; Bhui and Sashidharan 2003; Mayblin and Soteri-Proctor 2011). What this often means for non-state special services is, as Fassin and Rechtman elegantly summarise, “the price of liberty for these initiatives is their marginality” (2005, 354). All of this points to the costs and trade-offs of providing special attention to difference and otherness; a subject about which there is much more to say, and that will be discussed at various points in this ethnography.

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<sup>10</sup> Yet more recently, the official acronym grew to explicitly include Asian (BAME), then Refugee categories (BAMER)—a development made visible by looking back 15 years to Fernando’s (now apparently out-dated) declaration that “The current style in the UK is to describe all settled minority ethnic groups under one umbrella term ‘black and minority ethnic (BME) communities.’ This category excludes recent immigrants who are refugees and asylum-seekers. The main subgroups identified within the BME category are Asian...Chinese... black Caribbean/African-Caribbean...black African” (2005, 421).

What I want to point out here is that we are left with something of an impasse from these two sides of the debate and the paradoxes that ensue from it (which remain live in academic and wider public debate today). This is, in a way, puzzling, given that the influence of anthropology has the potential to provide possibilities for moving beyond such an impasse between psychiatry and the social sciences (Cooper 2016) or thinking “otherwise” (Restrepo and Escobar 2005) about problems that were perhaps once confined to small fields of expertise. The influence of anthropology within cultural psychiatry has done much to examine and disrupt ethnocentric, diagnostic approaches to mental health, through embracing notions of culture as relevant for psychiatry (Gaines 1992; Kirmayer 2005). It draws on ethnographic studies of “local cultures” to inform and critique clinical diagnosis and care of psychiatric conditions (e.g. Kleinman 1988). But its approach to ethical and conceptual questions of how to organise care (such as those I have been discussing here) tends to miss the anthropological commitment to close ethnographic observation of the everyday. There is a tendency to draw on established knowledge from within its discipline to make broad statements about how care should be done. I am interested in watching these debates and paradoxes as they “hit the ground”; how do the men and women who provide and encounter these “special services” participate in or (re)frame these debates in their everyday practices? How are big ideas such as “liberty” and “marginality” situated, sensed and enacted in particular places? How might neatly-formulated trade-offs between cultural sensitivity and equality get entangled in the messiness of organisational practice, emergent identities, and shifting boundaries between “the mainstream” and “other” services? In the following section, I focus on literature that follows this style of enquiry (though not these precise questions), and which is grounded in ethnographic work, generating further empirical questions on the topic of non-mainstream mental health care.

### *Counter-practice*

Tomas Matza’s (2018) ethnography of psychotherapeutic practice in post-socialist Russia arguably tells a story of “non-mainstream” mental health care, given its political and cultural exteriority to Euro-American psychiatry and psychology. However, the clinical field sites in this story focus on a municipal centre for child psychology and a private, commercial provider that enacted a kind of coordination between market and state, and a more general global agenda (seen also in Raikhel

and Bemme’s (2016) analysis of the “the psy-ences” changing relation to the post-Soviet state in the era of global mental health). This means I would not align it with the alternative, extra-state “counter clinics” that I describe below (or indeed that I examine in my own work). However, I do think there is much to be learnt from this text about some of the problems—about improvisation, precarity, and “doing things differently”—that I see in this body of work. As such, I instead focus on some of the counter *practices* that Matza identifies in the former (municipal) field site, which he describes as occupying a space in a “social margin.” This provides a case study that in some ways reflects a wider pattern of societies under economic austerity “pressing the therapeutic increasingly toward measurability” (ibid. 2018, 148). Supporting his claim, Matza cites several anthropological critiques of austerity, measurability and audit culture globally (Strathern 2000; João Biehl and Petryna 2013; Luhmann 2000). In the chapters that follow, I draw on one particular element of this, which is referred to in the book as “administrative legibility” (Matza 2018, 152).

Of particular interest in Matza’s Post-Soviet ethnography are the observations of tensions between these governmental norms and the practices carried out by practitioners. This, it is argued, is a result of the *indeterminacy* of legal and therapeutic norms in this centre. These indeterminate (or “fuzzy”) norms, in turn, opened up space for improvisations, such as crafting services with other municipal organisations and (on a more therapeutic level) refusing “the category of the cognitive,” or cultivating friendship in a therapeutic relationship. Crucially, however, these improvisations do not come close to anything like a reversal of power relations: the flipside of these spaces and opportunities is the danger they present to practitioners who might be accused of wasting resources or having no measurable impact. As such, the ensuing “precarious care” that Matza describes challenges any assumptions we might have formed about precarity being a sole concern for mental health practitioners working in extra-state or voluntary services. Is it something about the “counter—ness” of spaces *and* practices that makes them inherently precarious? Is there a specific mismatch between the indeterminacies in mental health care and measurability, which makes *almost all* therapeutic practice in this field risky and vulnerable to criticism, even failure? What other overlaps might we see between state/non-state improvisations or counter practices at the “social margins”?

### *“Counter-clinics”*

In my discussion of transcultural psychiatry and its overlap with medical anthropology, I challenged the idea (implied by trends in this field) that ethnography is solely for studying “local cultures” or “Others” that will receive care, or even the “cultural system” of psychiatry as the provider of care. In this paradigm, ethnography generally serves to help psychiatrists take seriously the cultural practices and beliefs of diverse patient groups. It also helps to critique traditional psychiatry, in order to present frameworks to “do psychiatry better”. This does important work—these critical voices are often from trained psychiatrists, meaning they are impactful and enable the successful “travel” of the discipline that has been well documented in anthropologies of psychiatry (e.g. Kienzler 2012). Yet, it misses some important opportunities to look at “culture” and “difference” *outside* of these realms of psychiatry and ethnic diversity, and attend to other oppositional ideas and practices in mental health, perhaps through different theoretical lenses.

There is now a vast and growing literature on peer-support work in mental health. Although this is beyond the scope of this thesis, I do want to draw attention to one particular ethnography that took place in the early stages of this trend. A now international network of “voice-hearers” was forming in the UK, providing mental health support through friendship and peer-to-peer therapeutic practice. Lisa Blackman (2007, 2001) worked closely with this user movement and put Roland Littlewood, Maurice Lipsedge, and others at the intersection of medical anthropology and cultural psychiatry, into conversation with feminist science studies and affect theory (Haraway 1998; Barad 2003; Brennan 2004). The Hearing Voices Network and her collaboration with it “represented a radical challenge to the alignment of body, culture and identity in the production and understanding of psychopathology” (Blackman 2007, 2). This approach is less about foregrounding the cultural over the biological, but rather to say that social and psychological life is “made biological,” partly through scientific practice but also in its entanglement with the body. What this kind of work tells us is that there are ways of looking at embodiment and the materialities of mental health and care without ascribing to hegemonic psychiatric

paradigms.<sup>11</sup> Equally, it avoids purely “cultural” approaches that pit spirituality and the psyche against the biomedical. As others have done across different contexts (Hyde 2016; Swerdfager 2016; Jain 2016), Blackman charts alternative organisations of power and expertise. In this case, it is done through a disruption of boundaries between expert and patient, science and culture, selves and others.

More recently, this notion of “counter clinics” was put forward by Elizabeth Anne Davis (2018) in her introduction to the special issue on this theme in *Medical Anthropology*, which aims to capture “new narratives” about psychiatry. The contributors work from an assumption that “DSM-style” psychiatry has become much less centralised and monolithic than it once was. Of interest to me, is the attention to the situatedness of these projects, “outside, alongside, or oppositional to mainstream psychiatric settings.” Moreover, I use this special issue to shine a light on current anthropological depictions of therapists working in “politicized and otherwise ‘alternative’ clinics” (ibid, 6). Alongside Sandra Hyde writing on rural therapeutic communities for drug-users, and Li Zhang on psychological training for urban middle classes in post-socialist China (Zhang 2018; Hyde 2016), this series includes Christiana Giordano’s (2018) ethnography of contemporary ethnopsychiatry in an Italian clinic for migrants. With particular relevance for my work, Giordano’s piece is interwoven with a historically situated account of community-based, diagnosis-free care of the mentally ill. What all of these papers have in common is that they think *with* these new modes of doing psychology and psychiatry, which exist in a fast-moving political landscape. This means their mode of critique is less focused on pure Foucauldian analyses of power and control (though many of the papers are deeply influenced by this approach) and more on the frictions and paradoxes that arise in these complex assemblages of state, psyche, individuals and communities.

Perhaps the most interesting example of this shift outwards, to a more dispersed and interconnected view of power and resistance in mental health than straightforward critiques of medicalization or social control, is Dominique Béhague’s (2018) contribution to the issue. The piece echoes, in some ways, earlier work in which she

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<sup>11</sup> Blackman’s later work on “immaterial bodies” (2012) provokes the idea that equally, we can, and should, attend to the psychic and the immaterial without giving up on ideas of the material and embodied.

has portrayed the “institutional expansion of psychiatric expertise” in all its heterogeneity and fluidity (Béhague 2008b, 141). In this work, connections (rather than polarity) between psychiatry, and institutions such as schools, the military, and community-based initiatives are foregrounded (Béhague 2008a). In the 2018 piece, however, she attends also to the making of a certain “kind” of psychiatric problem—“adolescent” motherhood—and the psychologised science that gained traction around this. A particular point of interest for me is her exploration of the ontological politics of how this problem was co-constructed by science, the clinic and the everyday (Jasanoff 2012), but *also* how it emerged as psychological suffering for *some* women but not others.

As I come to discuss in the rest of this chapter, and the thesis more generally, I am interested in the way categories or “kinds”<sup>12</sup> (such as “BME communities,” but also “vulnerable migrants” and “disadvantaged women”) play into the understandings and articulations of mental health “need” *but also* the way in which need is enacted and performed as eligibility criteria for care. If these categories or kinds (like “adolescence” in Behague’s work) are “good to think with” (Béhague 2018; Harding 1996), it is useful to ask: who is doing this thinking, and how does it help such categories gain or lose traction, in particular (counter) clinical spaces? I would like to return to problems of using the diagnostic model to determine mental health need, and to think through them in relation to oppositional places and practices, such as those documented in these counter-clinics. How, then, is need co-constructed between existing clinical frameworks, social categories, and various projects aimed at identifying and meeting “different kinds” of need?

In this first part of the chapter, I have set the scene within a particular sub-field of anthropological literature which has pointed to debates around various specialised services, as well as counter practices, and “counter clinics” which challenge mainstream models of providing mental health care. Through this, I have looked at the way in which articulations of human “kinds” bring certain needs into being, and in doing so, enable and constrain certain kinds of care and access to this care. In the

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<sup>12</sup> Behague uses “Kinds” in reference to Ian Hacking’s notion of “human kinds” that get produced through “looping effects” between knowledge of the object and the object itself. (Hacking 1995, 2006)

following part of the chapter, I look to a particular “kind” which has emerged both in global health and anthropology itself.

## **II. Problem spaces in the access literature (the case of “migrantizing” and “de-migrantizing” research)**

I now explore access through the lens of a particular matter of concern: migration, in/exclusion, and access to care. This shifts me away from a sole focus on mental health care, but provides something of a case study that encapsulates key issues that are relevant for my own work. It also reflects the contemporary turn to migration and mobility since the so-called “migrant crisis” entered public consciousness 2015<sup>13</sup>. I focus on this case as a means to explore the call to action, which mobilised researchers and professionals to attend to the exclusion of non-citizens from their rights to healthcare in “host” countries. But perhaps more importantly, to explore the formation of critical spaces that came along with this, and which I find useful in framing my own work. I highlight the ways in which this academic work has become generative and intervened in the world, making issues visible, mobilising or diverting resources away from them, *and* problematizing them within public opinion and advocacy. To describe this waxing and waning of critical attention, I use Dahinden’s (2016) idea of “migrantizing and de-migrantizing” the social science literature to structure this case. Through creating three specific “problem spaces,” which I describe in some detail, I treat academic work as an actor of sorts: the interests it represents, the traction it gains, and the distance it travels, has profound effects in the field of public health and in public life more generally. I point to the ways in which the field of migrant healthcare access has been (sometimes simultaneously) productive and problematic, and how this has shaped choices I have made about this project.

### *The making of a “global matter of concern”*

Attention to migration and migration studies has grown exponentially in weight, scope and economic value in the last two decades. As Janine Dahinden (2016, 1) has

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<sup>13</sup> Already, the narrative function of “crisis” itself has been challenged and contested in important ways (Andersson 2018; Roitman 2013).

noted, this has gone beyond simply being “in vogue, becoming institutionalized in degree programmes and specialised journals.” This has developed in tandem with building the research agenda on access to care, within a particular vernacular of rights and entitlement, producing it as a “global matter of concern” (Latour 2004b; Moser 2008). By saying it is *produced* as a matter of concern does *not* suggest that the problem is “made up” nor does it deny the embodied suffering or exclusion that restrictions to access cause. Rather, it is to understand that the visibility and political weight of a global field of knowledge and set of concerns, requires work to create and maintain. This set of concerns revolves around increasingly recognisable issues of universal rights to (mental) health (see discussion below on Willen 2011) and equitable access to healthcare and utilisation of services (e.g. Lindert, Ehrenstein, and Priebe 2012). This has been a productive “call to action,” mobilising attention and resources to otherwise under recognised areas.

The process of bringing these elements together and making a normative case for their investigation produces a curious blend of “the global” and “the local.” Despite the topic of migration being inherently transnational and the global, many of the scholars working in this field, particularly within transcultural psychiatry, strongly emphasise “the local” (Bhugra and Bhui 1998; Kirmayer et al. 2011; Fernando 2005; Tribe 2002). Here, there is an important critical point to be made about the category of the global itself. Bemme and D’souza (2014) critique the polarisation of “global” and “local” approaches in global mental health and its claims on the universal nature of human rights and evidence, and the idea that concepts such as *community* and *the social* are bound to the local. Thinking about migration, mental health, and access to care as a global matter of concern might usefully involve an “unravelling” of these discourses (Stubbs 2005). We might reframe these problems as neither specifically local or global but rather as a “problem space” for anthropological questions (Collier and Ong 2005).

I find Collier and Ong’s concept of the problem space useful to think with for a number of reasons, but chiefly because it generates critical reflection rather than an immediate solution. *As well as* a “call to action” this turn to migration has seen a wave of critical responses from anthropology scholars. In the sections below, I outline a number “problem spaces” that have opened up this topic to critical reflection. In

attending to them, it becomes clear that the call to action and the construction of this particular matter of concern was not only productive in terms of directing attention and resources, but in stimulating academic critique and debate: migration has become “good to think with” (Harding 1996; Béhague 2018).

*Problem space 1: bio-sociality and diagnosis as gateways to access*

One such space is a specific critical view on traditional frameworks of studying access to care. Alongside those who have critiqued the implied “tangibility” of *barriers* or *obstacles* for migrants (Larchanché 2012), this problem space interrogates the inherent helpfulness of *facilitators* to access for migrants. A now long-established line of critique, is the problematisation of psychiatric diagnoses being used to identify mental health need, and thus make people eligible for care. This gained particular strength with regards to refugees and asylum seekers in the 1990s, revolving largely around the emergence and controversy of the PTSD category. It was no doubt shaped by Allan Young’s seminal ethnography on production of PTSD in post-Vietnam war America (1995). Charles Watters (2001; Watters and Ingleby 2004) draws on Young’s work in order to cast critical light on the variability of epidemiological research on refugees and PTSD. This extended beyond questions of individual need, gaining particular traction when it exposed the pressures NGO and aid agencies felt to use the category to mobilise resources (Watters 2001; Stubbs 2005). These critical perspectives on the use and misuse of psychiatric diagnoses with refugees formed a sub-field for European-based critical “post-psychiatrists” (Bracken, Giller, and Summerfield 1997; Summerfield 1999, 2001, 2005; Bracken and Thomas 2001). What this work is perhaps missing, however, is a sensitivity to the afterlives of diagnostic categories: what happens to them as critique and psychiatric practice become so enmeshed?

A connected body of work has built on the literature on the strategic use of bio-socialities, and in particular the psychological condition of trauma in the governance of migrants and immigrants. In their review on the “production and management of risk, illness, and access to care,” Sargent and Larchanché (2011) dedicate a section to the political economy of migrant health/care, including a range of studies which have looked at the social production of sickness and the way it plays into the way migrant bodies are governed and managed. They draw particularly on Goldade (2009) on the way the “suffering body” has been used strategically to make claims on

the state (illustrating constraints on medical citizenship) and Larchanché (2012) on the turn, in France, to the “management of *socially deviant* and *psychologically distressed* African families” (p 347, emphasis added). A key problem with this, they imply, is the conflation of “cultural” or “ethnic difference” with “psychological difference” or even deviance. This builds on a longer critical tradition, which I described in the first part of this chapter, that shines a light on psychiatry’s tendency to “other” in more ways than one (Lipsedge and Littlewood 2005; Fassin and Rechtman 2005).

Miriam Ticktin (2006; 2011) and Didier Fassin (2012; Fassin and Rechtman 2009) have focused their attention on humanitarian logics in the governmental and public health response to migration, both globally and with a particular focus on the French context and its asylum laws (the “illness clause”). The first is the broad concern about how the new “vocabulary of mental health”, particularly in relation to migration in the French context, shapes narratives about socially marginalised people: what may once have been described in terms of exploitation or material deprivation is now expressed in a language of psychopathology (Fassin, 2012, p. 26). This reflects Metzl’s now popular call to replace “cultural competency” in transcultural healthcare with “structural competency” to avoid individualising the social determinants of mental ill health (2014). These critiques have powerfully shed light on the “sharp end” of migrant access to health and care in high-income settings, pinpointing how individual suffering can be co-opted as a means to govern and grant or deny citizenship. But what of the slightly greyer areas, where *inclusory* logics around migration remain ambivalent and fraught with more subtle (threats of) exclusion? The next problem space goes some way in addressing this.

### *Problem space 2: deservingness and the “right to health”*

A distinct problem space has formed around the question of *deservingness* to health and healthcare, which Sarah Willen (2012) has identified as distinct from both formal assertions of *entitlement* and *practical issues of access* (which in themselves can sit in tension with one another, as Liana Chase and colleagues (2017) have shown). Deservingness, Willen surmises in her introduction to a special issue to the problem in 2012, had been seriously understudied prior to that moment, pointing to the way it had been renegaded to the parenthesis of Ruiz-Casares and colleagues’ research question: “Which children (should) have the right to healthcare?” in an important

paper analyzing legal rights and access to healthcare for undocumented children (Ruiz-Casares et al. 2010). Willen's observation bears out in that most of the critical literature on migration and access to care has focused on specifically exclusory practices (Rousseau et al. 2008; McKeary and Newbold 2010; Arnold, Theede, and Gagnon 2014, for example), or illegality (Miklavcic 2011), though deservedness as a concept was not entirely new to the conversation (see Yoo 2002 for a print media analysis of "undeserving" older immigrants).

Another important shift is the increased attentiveness (often with an ethnographic gaze) on the practices and performances involved in the moral, ethical, value-laden work of providing access to migrants. Seth Holmes' (2012) long term ethnographic work on the clinical gaze on Mexican migrants in the US has, for example, revealed the "subtle blame" that practitioners lay upon migrant workers for ill health, despite saying they believed them to be deserving of medical attention. Also making use of the power of ethnography to complicate and reveal divergences in institutional care logics, Gottlieb and colleagues (2012) tease out the ways humanitarian healthcare provision, legal claims to individual rights, and an overtly political struggle against exclusion, all embody different definitions of "deservingness." Similarly, Marrow (2012) employs the idea of "deserving to a point" in her ethnographic analysis. In looking further into charity and humanitarian settings to complicate and further question the dynamics of giving and receiving care, ethnographers such as Darling (2011) and Huschke (2014) have explored practices of "constructing welcome" and "performing deservingness" respectively. Whilst both authors acknowledge the necessity to "fill gaps" in systems of care to ensure migrant communities can access services, they each problematise certain modes of belonging and deservedness: namely, how such modes of being are produced within imbalanced power relations and engender passive or docile recipients of care (ibid.)

Thinking about deservingness more conceptually, such questions can be understood as a means to interfere with or disrupt the seemingly simple notion of "right to health." Monica Greco (2004) has persuasively argued for problematising this notion in light of practices of privileging and silencing different voices that might determine "health" as well as "civil and political rights". Ultimately, she argues that the concept of health is indeterminate, drawing on the work of Georges Canguilhem (1991) to

talk of health not as a fixed organic state of being “normal” but as a set of socially and morally contestable *norms*<sup>14</sup>. She advocates for “placing indeterminacy of health at the centre of analysis, rather than at its margins” (ibid, 17), in order to allow for a wider range of possibilities for healing and health (beyond a singular scientifically rational one). This questioning of the singularity of health, and more specifically a “right to health” is something that Willen has taken forward with regards to a “migrant right to health”, urging medical anthropologists to “take it as an object of ethnographic analysis and explore how it is invoked, debated, and resisted in specific contexts” (2011, 303). Willen points out that *deservingness* (as a local configuration of moral and ethical commitments towards “illegal” migrants and other vulnerable groups) makes up the content of a “right to health” more than fixed national or international human rights law does. Indeterminacy and deservingness comes up yet again in Heath Cabot’s work on the social aesthetics of eligibility for Greek NGO aid for asylum applicants. Building on Fassin and Ticktin’s work (see above) on particular regimes of truth in asylum procedures, she argues that the way aid givers and receivers make sense of each other can also undermine normative frameworks of assessment:

“Even when aid encounters invoke normative... conceptions of truth, deservingness, and credibility... Eligibility determinations are, at base, deeply *indeterminate*.” (Cabot 2013, 454, my emphasis)

Though these problems have been grounded in ethical theory (which the theoretical framing of this thesis does not fully stretch to), these problems of indeterminacy and local commitments in healthcare are of interest to me. Given the now familiar arguments (outlined in the section above) against fixed diagnostic assessments of trauma and suffering, how do mental healthcare providers articulate different assessments of “need”? Could similar arguments be made about the *indeterminacy* of this need? Questions around indeterminacy—this time of healthcare *need*—has been raised within the bioethics literature (Juth 2015; Herlitz 2017; Gustavsson 2014) but from a purely theoretical perspective. Throughout this thesis, I explore how we can attend *empirically* to some of the local ways that mental health need is (re)configured

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<sup>14</sup> Greco (2004) moves towards an alternative to what she calls the “mainstream approach” which, she argues, bypasses this indeterminacy and focuses instead on resource distribution.

and negotiated, for migrants and other service user groups. I inquire into how need is enacted, made legible, or recognised as indeterminate, and to what end.

### *Problem space 3: vulnerability and precarity*

This is a problem space that reaches beyond the issue of migration and access to care but is nevertheless an important component of the broader critical perspective that I mentioned in the introduction to this section on the cultural template of “the vulnerable migrant,” which has become so salient in public health and rights discourse (Fassin and Rechtman 2009; Fassin and Rechtman 2005). The category is used to mobilise support within advocacy and policy for people without (secure) citizenship, and particularly for those in need of health or social care (Fassin and Burnett 2015, MIND commissioning guidance; The Lancet 2007; Langlois et al. 2016). I want to briefly chart some *different* conceptualisations and theorisations of vulnerability and precarity in relation to migration. Moving away from essential or static notions of who “is” vulnerable or precarious, I am interested in lines of enquiry that explore these conditions as “embodied,” “constructed” and “in the making.” I use them to think about how these conceptualisations might produce different directions in public debate and the organisation of services. As I outline below, critical scholarship from anthropology and elsewhere in the social sciences has raised questions about how vulnerability and precarity are “made” in various (structural, discursive, performative or enacted) ways.

One angle that vulnerability has been explored in relation to migrant experiences is through “embodied vulnerability” (Quesada 2012), which among other things, involves the accumulation of structural vulnerabilities or hardships that in turn cause ill-health. The idea is that these structural experiences shape subjectivities, which already takes us a step away from ideas (perhaps inadvertently propagated by the public health literature cited above) that migrants are somehow inherently vulnerable, or that this vulnerability is an abstract social category. Others have adopted a slightly different vocabulary: that of precarity, to describe “life-worlds that are inflected with uncertainty and instability” (Waite 2009, 7). This has been put forward to differentiate vulnerability as a *condition* from precarity as both a condition *and a possible point of mobilisation* amongst those experiencing it (ibid.). This frames the concept of precarity as pertinent to the experiences of particular groups in society,

and in particular migrant groups (for an overview of this nexus, see Paret and Gleeson 2016), This line of thinking feeds into the association between precarity and placeless-ness or displacement.

Others, in contrast, have invoked the idea of precarity as a more shared, existential state of being. Notably, Judith Butler has suggested that, although the experience of precarity is dependent on the organisation of certain economic and social relations, “no one escapes the precarious dimension of social life” (Butler 2012, 148), or, in the words of Lauren Berlant, in conversation with these ideas on precarity, “we are all contingent beings” (Puar 2012). In other words, no one person or group occupies an inherently precarious position; it is part of a common sociality that is constantly and variously *in the making*. This conceptualisation will be useful in the concluding part of this section, in which I summarise these critiques by looking at a call to “de-migrantize” research on this topic.

#### *“De-migrantizing” the literature?*

By way of a conclusion to this part of the chapter, I describe a current critical perspective that touches upon (though cannot fully encompass) all three of the “problem spaces” I have outlined above. This perspective has been usefully defined by Janine Dahinden in her “plea” for the de-migrantization of research on migration and integration (Dahinden 2016). I started this section by arguing that the vulnerable migrant category became a key organising principle in academic work on access and in/exclusion to care in high income settings, and that the creation of a global matter of concern around this category has been a productive “call to action,” mobilising attention and resources to inequalities and injustices in healthcare access. But I have also foregrounded a number of problem spaces that have opened up, in an equally productive (though critical) manner, around this issue of migrant access to care. Dahinden’s plea revolves around the argument that research into migration—with its entanglement notions of the nation state and ethnic difference—reproduces the categories (of nation states and social groups) and the “apparatus” of migration practice and discourse that it tries to critique. There is growing recognition, in and out of the academy, of the unstable nature of such categories; prompting many to try and disrupt the terminology used describe them. Sarah Willen, for example has taken to using the terms “im/migrants” and “im/migration” to “indicate that the

boundary between migration and migrants, on one hand, and immigration and immigrants, on the other, is both porous and shifting.” (Willen 2011, 325). I would argue that the critical voices I have discussed above, which comment on the conflation of ethnic “difference” with psychological “difference” (Sargent 2009; Lipsedge and Littlewood 2005) or the framing of migrants as somehow inherently vulnerable (Fassin and Rechtman 2009), all echo this broad idea that the “migrantization” of the social sciences has brought with it problematic consequences, as well as advocacy and the mobilisation of resources.

Dahinden suggests several strategies to “de-migrantize” this field of research, mainly from the migration studies literature, which aim to re-orient analyses towards parts of whole populations, and towards “common sense” categories (what I would probably call categories as *ethnographic objects*). However I end on two related but perhaps more ethnographically grounded viewpoints that open up some ways out of the impasse that she has described. One is Cabot’s recent project (following the work I cited above on the social aesthetics of eligibility for asylum aid), which inquires into changing notions of belonging and citizenship as “regular Greeks” experience forms of marginalisation under austerity that begin to mirror the experiences of migrants and refugees (Cabot 2016). Adding empirical weight to the conceptual conversation I touched on above about precarity in-the-making, Cabot has charted the “ongoing precarization of a [Greek *and* non-Greek] populace that increasingly does not recognize itself ‘at home,’” culminating in the recent fires which left “Greece burning” (ibid. 2018). As such, her work skilfully explores issues of belonging and non-belonging, place and precarity (important contributions from the field of migration and mobility) but opens up her analytical lens to reveal how these issues touch migrants *and* non-migrants in similar, different or surprising ways.

The other anthropological perspective that I want to draw upon that de-essentialises and complicates narratives about migration and diversity is Steven Vertovec (2007) and his now much-cited critique of Britain’s public understanding of immigration and multi-cultural diversity. Here he reconceptualises using a framework that he terms ‘super-diversity.’ Using London as a case study of a contemporary metropolis whose immigration history dates back to before the twelfth century, he charts the “diversification of diversity” that he argues has led to a complex interplay of

variables, challenging the old labels of ethnicity and/ or country of origin. He contends that as well as these socio-cultural differentiations,

“...immigrants’ channels of migration and the myriad legal statuses which arise from them are often just as, or even more, crucial to: how people group themselves and where people live, how long they can stay, how much autonomy they have... and to what extent they can make use of public services and resources (including schools, health, training, benefits and other ‘recourse to public funds’).”

(Vertovec 2007, 1035)

This has been taken up as a useful conceptual starting point for new ways of looking at urban mobility and diversity, which I will pick up on in the section below.

### **III. Access, inclusion and exclusion *in place***

In this part, I tell a story of convergence between several disciplines—human geography, science and technology studies (STS) and medical sociology—which medical anthropology has in various ways borrowed from, and which each have been influenced by medical anthropology. Whilst each disciplinary field has its own approaches to exploring access, inclusion and exclusion to (mental) health care with spatial and place-based sensibilities, I draw out important points of mutual influence. I seek to demonstrate how these disciplines are currently nudging upon a point of convergence, both methodologically and theoretically, which I tap into in my own work and positioning. I begin this section by staying briefly with the issues raised in the last part of this review, about the field of migration and its points of contention, offering a different (space and place focused) lens through which to view them. I use this to suggest a way of thinking about the (potentially problematic) migrant identities discussed above—or indeed any number of identities relevant to problems of “who gets access to what care”? This involves a re-framing from questions of *what*, or *who you are* to questions of *where you are*: what I call “spatialising the ‘identity trap.’” I argue that this is an important methodological shift away from static or identity-based framings of issues around access to care to more situated, place-based ones.

Although my first example is from anthropology, the beginning section focuses mainly on a subfield of human geography that has contributed to my literature base, particularly as I follow it to its “cultural turn” and specific focus on the study of care.

I go on to draw from the disciplinary field of STS, and in particular the translation of STS principles into the field of care and “caring architecture” (Nord and Högström 2017). This is where I introduce important concepts that I carry into my own methodology and analysis such as *enactment* and *relationality*. The final section picks up on pertinent areas of medical sociology, which also put these concepts to work. As such, I will be charting the convergence of three main disciplinary areas relevant to (mental) health, access to care and (in some instances) voluntary provision of services: first, human geography, then STS and material semiotics, and finally, medical sociology, focusing on the themes of “materiality, mundane care and moments of access.” I pull all of this together by identifying the theoretical underpinnings that help create this point of convergence, but which may also mask different gaps or unresolved problems, which I hope my own work will help to expose and intervene in.

### *Spatialising the “identity trap”*

Returning briefly to the problems associated with ideas of fixed identity-based categories from the last section, ethnographers have homed in on the inherently situated, spatial nature of access, in/exclusion and im/migration. The concept of super-diversity (Vertovec 2007) that I outlined in the previous section is something that Susan Hall (2013) has investigated spatially, through an urban street ethnography based in inner London. Rather than studying a particular ethnic or cultural community, Hall and her colleagues worked from a particular site in which super-diversity could be made visible at different scales (symbolic macro, collective meso, and intimate micro scales). The street is conceptualised as a “frontline of sorts” based on local understandings of its role as a border between the deprived and more affluent areas. As such, the site is described as a “place of reception in the city into which migrants arrive and share space with established residents.” (ibid., 10). This resonates with my own objective to study the flows (or lack thereof) of mental health service users into a space which is made up of an expressly ‘diverse’ collection of identities. Hall’s street is pertinent to many public or third sector healthcare settings, particularly in inner-city contexts, where the boundary of a particular place is also the threshold of a concentrated space of super-diversity.

The significance of the threshold/frontline/boundary space in relation to the movement of people in a contemporary “cosmopolitan” world, has been theorised in depth by anthropologist Michel Agier (2016) in his work on *Borderlands*. Although not anchored in any one site, his exploration of migration (drawing the work of philosopher Etienne Balibar) is decisively focused on spatial situations. The book opens with an emblematic scene where a particular configuration of young Afghan men, police, and local residents constitute a border control space at the port of Patras. But as the argument develops, we can see that the spatial conceptualisation of frontlines, thresholds, inside/outside, inclusion/exclusion, entitlements and/or deservedness, hospitality/hostility, and—perhaps most essentially—human encounters unfolds *without* the need to expressly study ‘migrants’ as such. This offers a key methodological approach with which to avoid what Agier terms the “identity trap” of using static categories to describe people’s subjectivities in contemporary movements; an approach which foregrounds contexts and processes to describe the “presence of the subject *in situation*” (Agier 2016, 136) Replacing the essentialised subject with the subject *in situ* is the theoretical shift underlying the proposition I made above, to move away from questions of *who one is* to *where one is* in explorations of access and inclusion in healthcare. Key to this is the concept of relationality of people and places, which I will explore more fully below.

#### *Micro-geographies of access and care*

Staying with anthropological investigations of migration and access to care for one more example, I refer to Parkinson and Behrouzan’s (2015) ethnographic work on therapeutic geographies and the politics of access for Syrian refugees in Lebanon. Their approach to studying health care encounters extends Dwachi et al’s (2014) ideas of therapeutic geographies, to “underscore the inherently variable micro-dynamics of healthcare access” (ibid. p.326). These micro-dynamics bear out in the data as specific encounters, such as an extended bureaucratic process in an obstetrics waiting room, which invokes rumour about care being dis-incentivised in this way for refugees on a much bigger scale in the host country of Lebanon. This supports and animates the ethnographers’ claim that their case exposes the “politics of access” rather than simply the presence or perception of services (as much of the qualitative literature of access to care does). When embedded in a broad socio-political understanding of context, then, a focus on the “micro”—perhaps counter-

intuitively—can offer a wider lens on the politics of access than “systems level,” population-based, or even qualitative research with a large population sample. There are elements to this argument that are drawn from a more general anthropological trope on the benefits of focused, situated ethnography, but the particularly spatial element of their argument can be traced to approaches in human geography, which I attend to below.

Human geography is about people and their spatial patterns and relations, and has generated a large body of work on “mental health geographies” (for reviews, see Curtis 2016; Philo and Wolch 2001). In the late 90s and early 2000s, human geographer and ethnographer Hester Parr (2000, 1997, 2011) built her work around “micro-geographies” of mental health settings in the aftermath of de-institutionalisation in the UK. Again, the “micro” is firmly embedded in the “political,” which is at once immediately close and expansive in scale. She would for example integrate her own sketch maps of the space with ethnographic field notes on a wide range of contextual material. Drawing on the classic ethnographic study of psychiatric patients in the US by Estroff (1981), she was interested in the “hidden social geographies” of what she calls semi-institutional places, given their position as voluntary services that had been appropriated by statutory health and social welfare departments following the closure of formal psychiatric settings. As do many of the ethnographies I have cited above, this in-depth work complicates straightforward conceptions of “exclusion” and social identity.

Rather than understanding people with mental health problems as consistently and equally “excluded,” Parr found boundary-setting around acceptable and unacceptable identities was done by staff and service users through individuals’ use of space, behaviour and bodily performances. This work was grounded in geographies of exclusion (Sibley 2002), the historical context of access and utilisation on mental health services (Philo 1995) and policy work on the restructuring of care into a contract system (Kearns and Joseph 2000). However, what brings Parr’s work (and the work that was influenced by it) much closer to the anthropological and STS literature I mainly draw upon is the long-term ethnographic engagement with particular places and the relationships that form within these places. What sets it *apart* from my work is its post-structuralist grounding and— in Parr’s earlier work at

least— a focus on identity formation and the way that disciplinary practices “leak in” from the “shadow state” (Wolch 1990). What happens when relations between state and voluntary settings become yet more blurred, and the distribution of power more difficult to trace? Could we re-conceptualise spatial ways of thinking about identity formation such that identity is not just a *product* of spatial (as well as power) arrangements, but rather, that it is *part of what makes up* space and place? Can we “represent” spatial arrangements using floor plans or indeed any static map? These are questions that begin to get answered through the convergence of this body of work with STS-influenced care literature. In the following sections, I draw these threads together using literature that speaks to my own work.

### *The “cultural turn” in human geography*

Continuing the investigation into deinstitutionalised mental health geographies, the growing reliance on the voluntary sector to deliver the care that had been the sole responsibility of state institutions captured the attention of scholars in what Wolch and Philo (2001) called the first and second “waves” of mental health geography in their review. Of interest are projects that provide ethnographic detail to the rather sweeping structural critiques on, for example, the “shadow state” thesis (Fyfe and Milligan 2003), the ability for the sector to meet welfare needs (Milligan and Conradson 2006; Fyfe and Milligan 2003; Dear and Wolch 2014) and mental health in high income post-asylum contexts (Milligan 2000). Against this backdrop, questions of care “captured the imagination” of scholars in human geography, which pulled attention away from policy and structure, and towards spaces, practices, and experiences in the field of health and welfare (Conradson 2003b).

Looking to the legacy of the “cultural turn” in this academic field (Philo and Wolch 2001) I am interested in projects which (with their ethnographic sensibilities) bring the discipline into particularly close contact with anthropology and related science and technology studies literature on this topic. Darling’s work (2017, 2011), which I mentioned briefly with regards to his ethnography of “welcome” in asylum-seeker drop-in centres, has also looked at how spaces are constructed around an ethic of care, whilst casting a critical light on the a-symmetrical (active/ passive, powerful/ in need) nature of giving in these contexts. Another shift towards a more affect-oriented and STS influenced approach is David Conradson (Conradson 2003a), who has paid

particular attention to the “doing [of] organisational space” in the formation of voluntary welfare settings in New Zealand. Compared to studies with a more classic geographical focus, such as those that (usefully) identify “marginalised services... for socially marginalised people” (Johnsen, Cloke, and May 2005, 334), Conradson’s approach to “doing space” opens up yet more analytical possibilities for understanding how—to stick with the same example—socially marginalised people might “make up” socially marginalised spaces, and vice versa. I will explain these analytical possibilities more fully over the next section.

### *STS, material semiotics, and care “in place”*

Science and technology studies (STS), sometimes known as “science, technology and society” or “science studies,” is a relatively young discipline, which has been concerned with social and cultural analyses of the knowledge and materiality of science since the 1970s (Law 2008). Closely connected to this is the field of “material semiotics”: the study of relations in their material and spatial context. These fields of scholarship are underpinned by assumptions of the reciprocal constitution, or *co-production* of facts, artefacts and meanings (Latour 1987; Haraway 1988; Jasanoff 2012; Pickersgill 2012). Much of this thinking is underpinned by actor network theory, which posits that all of these (human and non-human) elements are held together and interact in a web of *relations* (Latour 1987; Law and Hassard 1999). Relationality is a key organising concept, which insists that social and material entities are not only connected, but that they exist in their particular form *because* of these connections.

More recently, there has been a shift in the application of STS oriented research. These principles no longer focus solely on laboratories or the production of scientific knowledge, and are now often applied to topics and locations of care, such as those I have been describing above. What remains central to this way of thinking is that the world is constantly “in-the-making,” and the social and material are *co-produced*. As STS scholar, Ingunn Moser, has put it:

“objects and subjects, facts and artefacts, material and social conditions, social actors and practices are equally made and sustained in and by means of on going relations”  
(Moser 2017, 89)

Whilst it had been important to frame scientific “facts” and “objects” as relational products—i.e. “made up” in a network of relations (Latour 1987, 1992; Callon 1986), it also became necessary to talk about care as emerging not just from social interactions but also from spatial practice and production. To illustrate this point, Moser (ibid.) describes the architectural arrangements of a care home for people living with dementia: aspects of the garden, coffee table or hair salon that produce various possibilities for people to participate in social life. What animates the more difficult to grasp idea that these *places* are also produced and dependent on social actors is the ethnographic material describing the way a resident with dementia behaved in and *enacted* the institutional space in a different way to the way she, the ethnographer, was enacting it. The resident found herself on the unfamiliar territory of public transport, whilst the ethnographer (who introduces the scene as firmly based in the care home) was left to think about what we can learn from these multiple and contradictory enactments of space. This points to a second (though tightly connected) organising concept, which I adopt in my own work: *enactment*. Enactment is the process by which people and things, bodies and subjects, are constituted *in practice*; taking shape in their relations to one another (Mol 2002; Law and Lien 2013).

I too have been interested in the way that people accessing particular mental health settings might also be enacting or “making up” these settings. This provokes a very different angle on the relations between people and care providers, compared to public health ideas such as “candidacy” (Dixon-Woods et al. 2006) or “fit” between people and services (Lamb et al. 2012), which I described in the introduction to this thesis. If subjectivities and places do not pre-exist these encounters, how does that change the kind of questions we ask about which services are appropriate for whom? How might it shift traditional questions about people’s *experiences* of services, towards an engagement with *situated practices* and what they produce or enact, besides individual experience?

Perhaps most clearly in dialogue with the human geography literature I have described above, though firmly situated within STS and material semiotics, is Jeannette Pols’ work on mental health care in a context of de-institutionalisation in the Netherlands. Pols and her collaborators (Ootes et al. 2013b; Ootes et al. 2013a; Pols 2016) have considered questions of integration and participation as part of a

broader project about citizenship for people with long term mental health problems. The approach is grounded in “empirical ethics” (Willems and Pols 2010), which is aligned with the sub-discipline empirical philosophy, which Annemarie Mol (2002) is well known for. In the spirit of this approach, Pols has put forward “an empirical way of studying citizenship that looks at the relationships between people and the way these relationships are materially mediated and form social spaces” (ibid. 2016, 178). Looking beyond regional spaces such as the neighbourhood, Pols suggests ways of researching how people create new and different socialities such as caring communities amongst outpatients or online networks. Also central to this work is the relationality of people, material objects and socio-material space.

Although Pols’ approach resists being confined to thinking in terms of geographical regions, concepts of space and place remain central. A key piece of empirical work (which fed into Pols’ 2016 paper) presented a way of thinking about citizenship and belonging as “being in place” (Ootes et al. 2013a; Ootes 2012). Ootes and Pols’ ethnographic work in long-term mental health facilities pointed to the ideal of being “in-place” because it encompassed the sociality of inclusion and belonging, plus inclusion in the material environment; it also spoke to the material comfort of being “at home” without its static point of reference. This way of thinking about space draws from the STS principles described above, as well as concepts of “topology” from this field (Law and Mol 2001, 1995).<sup>15</sup> As such, space is thought of not just in terms of fixed buildings or coordinates, but in terms of how spaces are held together by notions of citizenship and other social phenomena. Just as Ingunn Moser talked of people enacting places, these authors engaged theoretically with the idea that “places can enact relationships” in mental health contexts (2013b, 16), citing Latour’s (1987) assertion that places and objects have agency of their own. This sense of symmetry between people and their socio-material environment (each “acting” on one another) is central to the concept of co-production in STS.

### *Materiality, mundane care, and “moments of access”*

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<sup>15</sup> Theories that draw on the concept of topology (originally drawn from mathematics) have sought to understand the social world spatially, but have pushed beyond classic understandings of space measured by two or three-dimensional coordinates. Building on actor network theory, they argue that there is also a network space, in which complex sets of relations hold objects together, or indeed, let them fall apart (De Laet and Mol 2000; Law and Mol 1995, 2001; Law 2003).

A final thread that I want to follow in order to bring together these converging disciplinary approaches to place and (access to) care is one that originates in medical sociology. This discipline, with its roots in the study of medical organisations and institutes, has become intertwined with STS as these scholars share an interest in relational logics and materiality (Law 2008). A recent special issue on the materialities of care (Buse, Martin, and Nettleton 2018) and new materialism (Brownlie and Spandler 2018)<sup>16</sup> makes visible just how much conceptual and disciplinary overlap there is between this literature and the bodies of work I have described above. The relatively recent sociological focus on architecture, for example, draws directly on science studies for “understanding how social relations are built into architecture” (Martin et al. 2015, 1011); whilst science studies scholars exploring “caring architecture” (Nord and Högström 2017) draw on work from human geography, to think through concepts like “therapeutic landscapes” (Andrews 2004; Rose 2012). Whilst acknowledging these disciplinary overlaps, I discuss the following work as a sociological conversation about how places and identities emerge, how place, non-place and liminality is experienced, and processes of inclusion, exclusion and access *happen* in healthcare settings. I am particularly interested in Joanna Latimer’s discussion of “moments of access,” and how these moments produce citizens (Latimer 2018; White, Hillman, and Latimer 2012, 73)—a concept I return to in my methodology chapter below.

The theme of being excluded and/or *out of place* has been explored extensively within this body of literature. In earlier work, Buse and Twigg (2014) were concerned with the notion of “looking out of place” in residential care settings. They describe the tension between the language of “home” used to describe these settings and the way in which they are often seen as transitory or liminal places such as earlier work has observed in hotel lobbies (Tallack, 2002). They argue that this interpretation by residents framed these care settings as more like “non places” (Auge 1995) than “homes,” and that practices of carrying a handbag were demonstrative of them feeling transitory and out of place. Another kind of liminal or in-between space that

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<sup>16</sup> New materialism, Spandler and Brownlie (2018, 257) tell us, “asks that we pay attention to human and non-human assemblages and the multiple relations within them, which include objects, people, relationships, emotions, resources and buildings as well as economic or legal processes, and cultural practices and expectations such as reciprocity. All these elements, new materialists suggest, have material effects.”

has been looked at through the lens of materiality is the waiting rooms that Susan Bell describes in her hospital ethnography of a service for immigrant and refugee patients (Bell 2018). Though inherently liminal (a “node that links the inside of the hospital to the outside”), only *some* of these places were “non-places” in that it depended entirely on the design features, conversations, and visual signs that came together at any one time. She argues that these spaces *can* “create solitude, anonymity and similitude” (Auge, cited in Bell, 2018) but they can *also* “create and enhance transnational networks of support that can flow into the exam room and out into the community outside of the clinic” (ibid. 2018, 318).

#### **IV. From Place to Milieu**

In this last part of the chapter, I have told a story of convergence between the three bodies of work around the theme of “situating access, inclusion, and exclusion.” Out of the literature I have been describing on materiality and place, well-formed (and now well-rehearsed) arguments have emerged about the co-production of social and material worlds. I go on to build on this body of work, particularly in Part One of the thesis, where my focus on *place* pushes the materiality of access to the foreground. *Place*, then, does the work of grounding this thing we call “access” in the material environment: it happens on thresholds, through doors, and in between-spaces like car parks and waiting rooms. It brings questions of who is inside and who is outside into focus, visually, as well as figuratively. We are made aware of inside-ness and outside-ness through the spatial and material features of care settings, and the practices that create and manage them. Place making and building becomes constantly relevant: dynamic and on-going, rather than a predefined background to practices of access and inclusion.

I have been describing the ways in which the analytical use of place has helped with the placing of people and identities: understanding them in specific situations, and therefore *in situ*. I have also charted the placing of care providers, moving away from their positioning in policy and structure and into the landscape of geographical areas, cities, and health and social care arrangements. Perhaps the most important point in all of this has been driven home by the material-semiotics literature: that the sociality

and materiality of place co-constitute one another. This means that place need not foreclose discussions of “the social,” social relations are built into the material environment, and socialities are shaped and afforded by that environment. Put differently, we social scientists have become confident in our analytical use of place to foreground the materialities of inclusion and exclusion in health and care, because of a refusal to let the material become detached from the social.

In the chapters that follow, I work up to conceptually extending my use of *place* to something yet more dynamic and more closely related to the multitude of *individuals* that encounter these places of care; whose *need* their care is organised around. This conceptual extension takes me to the notion of the milieu, which comes into play in Part Two of the thesis. Milieu is most commonly known as a person’s social environment, though it has roots in the physical and natural sciences. It is a notion with a complex and various genealogy in science, philosophy, and therapeutic application. There are, for example, writings from the eighteenth century on milieu as fluid matter and a whole body of psychiatric work and practice based on the idea of the “therapeutic milieu” developed in the late 60s. However, I seek to employ it in a particular and rather more conceptual way, referring to a vitalist approach to the problem of the individual in their environment (Canguilhem 1952/2001). In doing so, I join current conversations on the milieu: in medical anthropology, for example, Hannah Landecker and Todd Meyers in a recent collection of texts revisiting Canguilhem (Coren and Brintzer 2019) and from a little more distance, Biehl and Locke (2010); as well as in social theory (Eyers 2013; Greco 2019). In the thesis, I keep my discussions close to my ethnographic material, rather than venturing too far into theoretical discussions about the history and genealogy of the concept. However, I devote a little space here to make clear the theoretical genealogy of “milieu,” the different meanings that emerge from it, and what it does (and does not do) in the context of my own work.

### *Which Milieu?*

I have alluded to the many different versions of the concept of the milieu in the social and life sciences. My interest with the notion of milieu in relation to need came from the essay of Georges Canguilhem, *The Living in its Milieu* (Canguilhem 1952/2001). The essay seeks to identify the meaning and value of milieu as a “category of

contemporary thought” (ibid, 7) through its forays through the ages of the life sciences. Threaded through this history, however, is the author’s own orientation towards a particular form of vitalist philosophy, which is concerned with life in its many forms and processes: both human life and beyond. And so, whilst a multitude of understandings of the term and concept are discussed, one theme running through it is the difference between Canguilhem’s vitalist ideas of the milieu, and a more mechanistic notion of milieu as “outside surroundings,” grounded in Newtonian physics. What I take from this argument is that the idea of “surroundings,” defined purely by their static exteriority, does not allow for the lively, vital, or radically relational conceptualisations of place that become possible through Canguilhem’s lines of thinking. Such static “surroundings” are reminiscent of the stubbornly inert background that characterises so much of public health discourse on “context”. Similarly, thinking of milieu as a set of “influential circumstances,” working mechanistically *on* the organism, smacks of the causal, linear problematisations that characterise many intervention models in healthcare. As such, mechanistic notions of environment or context fail to engage with the on-going, dynamic way in which the living shapes its milieu as a function of its values and needs (Canguilhem 1952/2001, 9).

It is the more relational, vital notion of the milieu that I draw upon in my work, and which helps me to think through the problem of *need in place*: the dynamic emergence of mental health need in particular places of care. More specifically, I draw on two key elements of Canguilhem’s milieu in my work, to conceptually extend my ideas about place. The first, which I have already begun to describe, is the relational space, centred around and shaped by living individuals. Where places are defined by a more straightforward relationality between inside and outside, Canguilhem’s milieu conjures a more radically relational idea of inside/outside, centre/periphery, which is a function of how environments are lived, made by, and constrain *a multitude* of people and other organisms. A vitalist understanding of milieu is therefore relational because it is never a given: it is constituted by the living things that inhabit it. And it is multiple because it is centred around each and every one of these living things, and never a totality. For me, this is crucial to understanding how I come to describe the emergence of forms of mental health need in psychotherapy centres: that these centres do not impose particular forms of need on people, yet nor do their needs or

the milieu exist independently from the encounter—the moment of access. I go on to describe the dynamic emergence of need in the relational space of care settings, working alongside and in tension with the more bureaucratic constraints of mental health care.

The second element of Canguilhem’s vitalist milieu that I draw upon is the *ethics* of putting the living—in this case, individual humans—back into the story of the story of place. Practices of knowing individuals and their needs emerge in the ethnographic material that follows as a powerful organising principle in my field sites. Canguilhem’s vitalism allows me to attend to the humanist ethics of my interlocutors, whilst maintaining a commitment to the productive “liveliness” of that which goes beyond the human: places, the material practices of access, and so on. In the words of human geographer Chris Philo, talking of Canguilhem as a forerunner of post-humanism, “...he *can* arrive at ways to hold both vitalism and humanism ‘in suspension’ relative to one another” (Philo 2007, 97). This moves us closer to contemporary readings of vitalism, which privilege its relational and processual commitments (Fraser, Kember, and Lury 2005) as well as its ethical demands (Greco 2005). In bringing the “living” back in, I hope to attend more carefully to the presences and absences of “humans in need,” which the work of inclusion and access was organised around in my field sites.

A final word on the question of “which milieu?” responds to the fact that the concept continues to be revitalised and used anew. Notably, Biehl and Locke (2010, 2017) have, with broad reference to Deleuze, employed the notion of the milieu in order to talk of an “anthropology of becoming.” Their rethinking of “being” to “becoming” (a state constantly enacted though time and space) resonates with my broad thinking about life as an inventive, relational process. I too engage with Deleuzian ideas about people and places as changing, unfinished things: I have been fascinated by their famous rhizome, which has “neither beginning nor end, but always a middle (milieu) from which it grows and which it overflows” (Deleuze and Guattari 1988, 21).

The way in which Biehl and Locke adopt these ideas, however, diverges from my own ethnographic use of the milieu. These authors are concerned with rather more grand narratives of hopes and desires in relation to structural violence and social

suffering (João Biehl and Locke 2010). The temporality of becoming through these narratives that Biehl and Locke use to describe “a people yet to come” (ibid.) directs our attention to life-stories and imagined futures—a more classic domain of anthropology. But what about the moment-by-moment emergence of need in a given milieu? What I am interested in is a more modest idea of *moments in place*. The entities that “become” at these moments are in a different kind of movement: one of adjustment, improvisation, responsiveness to place and its demands. As the ethnographic material unfolds, it also becomes clear in *my* work that the milieu incorporates the precarity that is inherent in need, care, and living, rather than being the backdrop for stories *of* precarity and suffering as in more classic anthropological approaches.

My focus on vital concepts of need and milieu, rather than distinctly Deleuzian ideas of desire and wide-open “becomings,” is important for me because of the kind of problems it orients us towards and helps us to re-think. By this, I am thinking back to the problematic set up in the introduction: the public health model of “meeting the need,” working from centre to periphery. How might we re-think this, given the more dynamic, relational processes, located in space and place that I have been exploring here?

## **V. Problem (re)formulation, aims and questions**

In light of the ideas I have been discussing above, I want to revisit the “problem” as I have described it in the introduction as a public health problem. As it stands, I see a notion of “access” through the lens of public health and psychological services, which I have argued is less of a public “*good*” as it is an inherent *problem*. I have described this problem in terms of the persistence of vast inequities and discontent with levels of access to (mental) healthcare, and in particular, to talking therapies in the UK—a high-income country with a supposedly “free at the point of access” model of healthcare. I have also pointed to two contemporary policies that have been put in place to tackle the problem of access to mental health care in this context: one is the national “roll out” of Improving Access to Psychological Therapies (IAPT) programme and the other is the “any qualified provider” policy of the Health and

Social Care Act (2012), which deploys voluntary services to provide mental health care to underserved and specialised groups who find it harder to access services via mainstream clinical routes.

Already, a contradiction emerges. “Access” has been framed as a universal problem, to be solved by putting in motion population wide, evidence based medicine logics, whilst *at the same time* it has been framed as a problem of certain communities with particular needs. The seemingly straightforward problem of “not enough access” meaning high levels of “unmet need” in mental health care becomes therefore difficult to uphold, much less solve, in its current formulation. I see a toolbox emerging from the existing work on this topic, at the intersection of several theoretical and disciplinary fields, which helps me generate new ways of thinking about this problem, through crafting questions that are not only answerable but “inventive” (Wakeford and Lury 2012).

One of the aims of this thesis, then, is to reformulate the “problem” of access, using both the existing scholarly work I have been synthesising here as well as my own ethnography. It is at this point that I begin to identify an *anthropological* problem, from the array of perils (in the literature I have discussed) that appear to come with addressing shortcomings and inequalities in access to mental health care. I have shown that these perils are not just the ones we are now familiar with in medicalisation or “psychiatrisation” narratives, where psychiatric diagnoses silence other ways of understanding mental distress. They also cover the perils of countering this psychiatric dominance with “special” services: perils of reifying ethnic, racial or cultural difference and of trying to pin down complex or even indeterminate concepts such as “health” or “need,” to reiterate a few that I have teased out of the literature above. I am interested in addressing these more anthropological problems around difference and mental health need in my work. I have drawn inspiration from wider literature to breathe new life into these problems, by foregrounding place, space and socio-materiality in my investigation. One way I do this within the thesis is by quite literally frontloading the data chapters that revolve around themes on *place*, ordering them to form “Part One” of the ethnography and following with my analysis of *need* within these settings in “Part Two”. In the discussion chapter, I reflect on what this problem formulation does analytically, and importantly, what it might do for care

providers in the voluntary sector, who are increasingly being positioned as a “solution” to the problem of access and unmet need.

I argue that this approach to the research problem is an important shift away from static or identity-based framings of the problems of access to care, to a more situated, processual and spatialised one. But this must be operationalised in the methodology as well as the conceptual work of this project. This leads me on to the next aim, which is to observe and describe access “in-place”: by this, I mean generating data on access and inclusion in particular places, and further, by treating “place” as a product of spatial practices, materials and relations. I am interested in how place comes into being through the practices of accessing care, and including or excluding potential service users in the three psychotherapy centres that were my field sites. I developed a creative “mapping” method, which allowed me to explore how these centres were constantly being “made” and “remade.” As I go on to show in my data chapters, this was sometimes done quite literally from scratch, due to financial pressure and a changing urban environment. At other times, place making was achieved through the everyday work of (material and metaphorical) maintenance of spaces and their boundaries. Here, I ask how these processes might play into notions of the “counter-clinic” defined by its “differentness” to the mainstream, broadening my analysis of boundaries and relationality to different scales within the broader landscape of care.

Inspired by work in the field of material semiotics and notions of the “liveliness” of place, which I have described above, I push these ideas yet further, considering how place might, in various ways, be an *active medium* in these field sites. This will inform the research aim and questions for the second part of the ethnography, about the enactment of mental health need. As I have outlined in the literature review, I am interested in “different kinds” of mental health need and how “different kinds” of care providers recognise, articulate and operationalise this as eligibility criteria for accessing care. In particular, I am interested in how this is done in the absence of, or *in relation to*, mainstream clinical frameworks such as diagnostic classifications. Throughout this thesis (though more intensively in the second part of the data chapters), I aim to describe and analyse the processes, practices, discourses and spaces through which mental health “need” comes into being. I deliberately leave my conceptualisation of need open and do not attempt to answer the question of what

need really “is.” Instead, I investigate how need is articulated and enacted by different social actors, considering how it enables access to care. In other words, I am more interested in what need “*does*” than what it “*is*”

The above aims and questions I have been posing throughout this chapter can in fact be pulled together to capture this dual focus on *place* and *need*, in order to reformulate and eventually respond to the “problem” of mental health care access. The overarching aim, then, is to investigate how “place” and “need” *co-produce one another* in voluntary sector mental health care, and how these insights might, in turn, help to produce a situated and critically engaged notion of the problem of “access.”

### Chapter 3: *Placing need*—a methodology

“We” [the “knowers”] are not outside observers of the world. Nor are we simply located at particular places in the world; rather, we are part *of* the world in its ongoing intra-activity (Barad 2003, 828)

Placing need/need in place: the structure for the chapters that follow could go either way, though I have chosen to let “placing” drive much of my methodological approach. And so “place and need” has emerged as a structure, but might better be re-formulated as a methodology, or a methodological sensibility. It is a way of coming to know the problem of “access,” which attends explicitly to the processual and practice-oriented, the non-linear, the relational, the material, and the vital. First, I give a brief rationalisation of these organising concepts, before introducing the main body of this chapter.

I crafted my methodology to attend to the *processual and practice-oriented*, because I needed to direct my focus away from categories as fixed entities, particularly in care settings such as my field sites, where diagnostic and social categories abound but are also contentious and subject to discontent and change. In my research questions, I have therefore framed “need” as eligibility criteria, to be enacted and put to work by both users and providers of these services in particular situations; it was the job of my ethnographic methods to help me notice and understand how this work unfolds. I attend to the *non-linear*, because of the scepticism I had initially about pathways and “barriers and facilitators” models of access, and because (later on in the research process) when I tried to analyse people’s stories as continuous narratives or “journeys” I found much more fragmented data and few causal pathways to the events I observed. I see the world as *relational*, because how else does one study sites and populations that are defined by “difference”? (To think about “being different” as anything *but* relational simply makes no sense: different to what?). I have also found that relational thinking can be pushed further than simply making sense of points of sameness and difference: by seeing the world as it is produced by

relationships, I started to see the *constant production* of sameness and difference, and of universality and alterity. I looked to the *material*, because I was curious to understand how the ubiquitous spatial metaphors in discourse about access to care (gaps, bridges, doors, pathways, and so on) related to the material environment and a more grounded notion of being in (or out of) place. As such, I attend to the “liveliness” of places, in order to engage with ideas that foreground the non- or “more than” human. I do this not to divert from the humanness or immateriality of social and psychological need, but rather to *locate* this need, and potentially subvert linear logics of need as a pre-existing entity, to be determined diagnostically and then referred to particular inert places within a system of care. This speaks to a broader commitment to the *vital*, or a *vitalist* approach (introduced in the previous chapter), inspired by the philosophy of Canguilhem (Canguilhem 1952/2001; Canguilhem 1952/2008; Canguilhem 1943/1991), which attends to places, individuals and their needs in their unfolding and their absolute relationality (Fraser, Kember, and Lury 2005; Greco 2005; Philo 2007).

Together, these ways of thinking about and working in the social world have been productive, not just in producing knowledge about this world but by engaging with the productivity of practices themselves (Law and Lien 2013), by re-animating what may seem static or inert (Ingold 2010) and by developing methods that are in essence inventive (Wakeford and Lury 2012). To theorise “place and need” as assembled, co-constituent, and *in-the-making*, I see it as necessary to participate and engage in this making. I start this chapter with a precursor to this making: a series of reflections on *becoming interested* in the field, which serves to say something about my positionality and ethical approaches to fieldwork. I go on to describe the explicitly “creative method” that I developed in order to embed this inventiveness and engagement with “place” into my formal interviews with users and providers of these services. In the final section, I focus on writing as a method to record, analyse and perform the social world throughout the ethnography, giving examples of how this helped me bring out my findings in the different parts of the thesis.

#### *Overview of the fieldwork: An ethnography of access*

I have used these practices of *becoming interested*, *mapping and tracing*, and *writing* as heuristic devices to bring out what I consider the most pertinent aspects of my

research practice, though of course, these can encompass only a fraction of the choices that I made, the modes of data gathering I adopted, and the ways in which I went about analysing this data. I therefore give some space here to provide a very broad brushstroke picture of what the fieldwork looked like.

My methodology was ethnographic and employed a range of qualitative methods in order to generate different kinds of data. I engaged in participant observation (though as I describe below, my participation was inherently partial), based mainly in the three voluntary clinics I selected as field sites, throughout the fifteen months I was “in the field.”<sup>17</sup> I went through the London School of Hygiene and Tropical Medicine ethics procedure, and, at the point of starting of my fieldwork, gained permission to gather data according to a specified protocol.<sup>18</sup> As I detail below, however, I took a largely processual approach to my ethical practice, iteratively assessing and adjusting my work according to situations as they arose within the everyday application of my research methods.<sup>19</sup> I spent approximately three cycles of six to eight weeks in each site (and any further places this led me to in the community or other non-NHS services), with the first cycle focused on observing and establishing my role in each place; the second on recruiting and interviewing service users, whom I would usually meet once or twice before a main interview; and the third interviewing the service provider staff, whom by then I knew well, with various degrees of intimacy. In my writing about these encounters, I make every effort to protect the identities and privacy of my interlocutors; I use pseudonyms for people and places, sometimes using only an initial or changing small details where necessary.

I selected the foci of my observations and interviews according to my topic and research questions, considering my material and conceptual area of interest to be situated *around the doors to each service*. This meant I was primarily interested in any practices and topics that related to processes of referring, accessing, waiting,

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<sup>17</sup> This period is not clearly defined, as I was (and remain) based in London and in relatively close proximity to all of my field sites, meaning on-going scoping work took place before this time and I am able to remain in contact with the field even now.

<sup>18</sup> This included standard procedures for gaining written informed consent for interviews and written permission from clinical directors to conduct participant observation in the centres, informing other staff and clients of my presence through information posters, sheets and oral communications.

<sup>19</sup> I recorded ethical issues in my field notes and incorporated local (organisational) ethical guidelines as I encountered them and continued on-going contact with the ethics committee to build and amend my methods in response to the demands and possibilities encountered in the field.

assessing, allocating, and so on; right up until a client fully entered into a therapeutic space and relationship with their therapist. This meant my analyses “stopped” when it came to the therapeutic work itself. Conceptually there was no clear line about where this was (some therapists felt the therapeutic work started as soon as clients crossed the threshold, for example) but I never observed one-to-one therapy sessions, which I considered a methodological and an ethical choice, as much as a simple limit to my own “access.” Observational work took a wide range of forms, which I detail below, combining volunteering, shadowing and observing clinical meetings and other staff practices. Through this, I had countless conversations, discussions, debates, and so on, with staff members. I also conducted one or more formal interviews with fourteen of the therapists and staff members, most of which also involved the creative visual method I describe below in the *mapping and tracing* section.

I had far less on-going contact with service-users, who flowed in and out of the centres in short cycles of therapy and spent only a fraction of their time in the centres outside the therapy rooms. Aside from the time I spent with service users in the waiting rooms, and through my recruitment of people to take part in my research, all of my data with service users was generated through interviews. I interviewed twenty-five people in this way, sometimes more than once. On two occasions I held group interviews with members of a new therapeutic group. Usually these took place in the centres, in whichever quiet space we could find (which oddly often turned out to be a therapy room), though I also met people whom I already knew in cafes or their homes. I have tried to write all of these places in to the ethnographic material, foregrounding them as social spaces as well as clinics, research locations, and the broader, shape-shifting space of the much talked-about “community.”

## I. Becoming interested

The popular ideal of science is thus made of a mute disinterested scientist letting totally mute and un-interfered with entities run automatically through sequences of behaviour. But... The path to science requires, on the contrary, a *passionately interested scientist* Latour (2004a, 218)

What did it mean for me, as an ethnographer to be *interested* in my field site and in the people I engaged with? How did I *become interested*? In the text I quote above, Latour is saying something about how good science should be done: arguing with others<sup>20</sup> against the canon of modern philosophy of science, he gives primacy to the “interests” of the researcher and the “interestingness” of the entities that she is researching. I want to dwell here on a double meaning of *being interested*, which I see coming out of this text, and which is pertinent to the way I was positioned in the field. I use the notion of *becoming interested* to refine and bring together this double meaning, and to talk about how I became sensitised and affected by the worlds I inhabited during my fieldwork.

My selection of these three centres was made according to how they would make my research questions answerable, but crucially how these answers would be *interesting*, both in terms of the “matters of concern” that I highlight in my review of the literature, as well for as my own lines of inquiry. As I go on to show, this was an interest that I built up through engagement and the building of relationships: there was a reciprocity to it, which was important for accessing the field. My own access to the field was realised through first engaging with one of the centres, which I call Culture in Mind, volunteering with them over a period of time in which I was seeking out links with other third sector providers in the area. I eventually made the decision to work with the consortium of providers that had recently formed around Culture in Mind in a typically strategic move for small organisations to secure clinical commissioning contracts within a certain area. I came to this through a process of becoming embedded in this first organisation, building an understanding of how this

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<sup>20</sup> Latour is referring to Isabelle Stengers and Vinciane Despret, who argue for an “alternative normative epistemological epistemology,” to that of Karl Popper’s falsification principle.

centre sat within formal and informal networks of care provision (that is, networks built on commissioning and other funding structures alongside those built on years of friendship and alliances). The consortium, the three separate organisations, and (later) individual encounters and moments, all made up different versions of what could be called “ethnographic cases.” Each kind of “case” was interesting for their own *particular* reasons but also in relation to a *general* interestingness: how a person fell into a general “client group,” or how each organisation was part of the broader consortium, for example.<sup>21</sup>

It is important to say that I wasn’t the only one who found my field sites interesting. I learned quickly that the first centre I engaged with often captured the imagination of outsiders. The centre had been operating from various sites with the same inner-city area for over thirty years and its capacity for “interestingness” would at times exceed its physical capacity. I heard the “Scandinavian students” story several times as testament to this: a group of young clinicians came to visit the centre, having read about its alternative, cultural approach to psychotherapy on their training programme and wanting to set up their own centre for refugee mental health. Entering the small clinic space at the top of an office building, they had exclaimed how tiny it was, appalled at how insignificant it appeared compared to how far its ideas had spread. That was then—some fifteen years ago— but 2016 was the year I started my fieldwork and the year after the “refugee crisis” hit Europe. It was the peak of the contemporary “global matter of concern” around migration (as I described it in Chapter 2) and the centre seemed to be more interesting than ever. Over those months, several thinkers and writers came to ask the therapists about the psychological fallout of current migration politics that they encountered day-to-day.<sup>22</sup> This place, at least, was *already* interesting. The other sites had their own, connected versions of this—projects that went to the heart of contemporary understandings of

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<sup>21</sup> Yates-Doerr and Labuski (2015) had recently reignited scholarly interest in the “ethnographic case,” inviting anthropologists to consider the “tensions between the general and the particular” it invokes through a series of 27 contributions to their Somatosphere blog project. A related set of reflections had also been compellingly articulated by Berlant in her more general commentary “On the Case” (Berlant 2007)

<sup>22</sup> There was the Cultural Studies professor, who came for the afternoon to investigate how psychoanalytic therapy reached poor migrants within contemporary megacities, avidly collecting case studies from the most senior therapists; and the young journalist who wanted to link clients’ experiences to her own story of being born in a refugee camp in Somalia and bearing witness to her mother’s struggle with the mental health system in the UK.

psychosocial suffering (migration, gender-based violence, bereavement, to name a few)<sup>23</sup>. Attached to this was another set of issues for me, when it came to being interested in the life-worlds of people who were being (in some projects) defined by their difference and minority status. Not sharing their minority status in the wider context we were inhabiting could attach my “interested-ness” to my whiteness, and the “interestingness” of particular field sites to the “otherness” of the people they were designed for. This is a dynamic that resonates with Cabot’s exploration of xenophilic responses to migrants in Germany and Greece as a kind of “consumption of the stranger” (2017, 143). This was a spectre that could never be entirely resolved through methodology, but can at least be unsettled and challenged in ways I go on to talk about. In the next section I reflect on what makes it worthwhile talking about “being interested,” in light of these uncomfortable associations. What makes it a precursor to this engaged and “inventive” approach I have been describing above?

### *The interested volunteer*

One important way to broaden out this concept is to think about being interested not simply as finding something interesting, but as the opposite of being *disinterested* (a “mute disinterested scientist”<sup>24</sup>): of having *vested interests* in people and places. My interests formed, and sometimes changed throughout the time I spent with these organisations, largely through volunteering and investing in relationships with staff and other volunteers. This begins to answer the question of why *this* conception of interestingness requires methodological work to make it reciprocal: to make it into a quality that is co-constructed between researcher and researched. This goes against many enlightenment ideals of “good science” because it implies non-neutrality and a potential for “bias,” but these ideals are precisely what many people have railed against in their critiques of entrenched hierarchies of knowledge and modes of knowledge production (Haraway 1988; Latour 2004a). The politics of such methodological rebellion has perhaps been best articulated beyond science studies, for example in the postcolonial feminist maxim “*the master’s tools will never dismantle the master’s house*” (Lorde 1979/2003; cited in Ahmed 2017), which similarly seeks to

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<sup>23</sup> This is in contrast to the “interestingness” that Vincianne Despret (2006) talks about having to learn about, and rethink, when it came to studying sheep: a particular non-human group which is traditionally thought of as rather more uninteresting than people engaged in therapeutic practice.

<sup>24</sup> The “mute disinterested scientist” is in the words of Latour (2004a), quoted above, which cites the work of colleagues Stengers and Despret.

disrupt and subvert the canon of the tools of the academy. Through the following examples, I demonstrate how shedding the safeguard of the “disinterested scientist” label was a vital element of the kind of ethnography I was engaged with; how it also carried ethical implications and dilemmas, and how it provoked active shifts in my own subjectivity as I moved through different places and moments in the field.

Throughout the time that I was engaged in my fieldwork, my interests as a researcher, there to “collect” data, became blurred with interests that emerged as a volunteer, as a friend to some, and as an advocate (and at times a critic) of the work that I was witnessing. This was of course part and parcel of the world I was a part of: interests were driven not by money, since there was so little to be invested or gained, but certainly by values, interests and the relationships that formed around them. This could be fraught: I saw the bitter disappointment of a senior therapist who took on a role, motivated by friendship and by a commitment to feminism, only to find herself feeling exploited and overwhelmed by the organisational pressures; volunteers operated on the assumption that they were working within the same value system as paid staff but this could go awry and their investment could be dropped in an instant. Next to (and with further blurring into) the shadowing and observational work I did, I too volunteered in all three sites, working more intensively in each for three cycles of several weeks at a time. I do not suggest that my volunteer work was subject to the same pressures or affective involvement as these long-term members of staff, though I do want to highlight here the ways in which my engagement nudged me closer to an “insider” perspective, sensitised to these dynamics, if always from the peripheries.

I never conducted clinical work, not having been trained in psychotherapy, but my background in psychology helped take off the “outsider” edge to my role as ethnographer. I worked on community projects such as outreach events, helped organise and document conferences, created promotional material, represented the organisations at external events, gathered information and data for funding proposals; I worked on the reception and proof-read letters and legal statements from therapists for whom English was a second language; I helped set up a book club for critical reading and discussion at one of the centres, and developed the training material and inductions for the many new trainees that invested volunteer time. When one of the centres moved location, unable to keep up with the rising rent

prices in its area, I participated in the packing, unpacking and place-making of the clinic (in its fourth location to date), and helped clear the outside space of another centre when clients began to get disconcerted by the rubbish and abandoned cars that were dominating the small street it was located on. The role with the most blurry boundaries I took on was the setting up of a research team in the centre that was most discontented with the monitoring and evaluation systems they were subject to from their contractors.<sup>25</sup> This work could be seen as a simple investment in these sites in return for “data” (the familiar gift exchange between ethnographer and her interlocutors) but of course this work not only *became* “the data,” but also, I became more and more invested in the work itself: our interests began to blend. In sum, the volunteer work was first and foremost a way for me to gain access to these sites but it also became valued by the people I was working with and (I like to think) had its own effects in their world. Having effects and being affected: more on this below, but first a note on interests and ethics.

### *The ethics of being interested*

Where do interests and interestingness clash? Where does this reciprocity idea (where interestingness gets forged through the production of shared vested interests) fall down? Client stories were in themselves, of course, “interesting” but I came to find that this gift-exchange strategy of offering my time as a volunteer did not, on its own, provide an opportunity for me to become invested in the lives of service users. Neither did it allow me to really blend my interests with theirs like I did with the staff—my involvement was much less directly related to the service users, at least until I had already made contact with them to meet for an interview. I was confronted with this indirectness fairly early on in the fieldwork, when my main concern was with “gaining access”—the more the better, or so it felt. Here, I dwell on one ethical issue that arose during this process of gaining access and coming to terms with my own interests and stakes in the research in relation to others’.

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<sup>25</sup> Together with non-clinical staff and volunteers, I set up a research team at the centre and devised an alternative qualitative monitoring system of client experiences, which became an on-going narrative research project. Several of the clients I piloted this with became part of my own research, and as well as being informed by what I found in the monitoring work, I went on to meet with them (sometimes outside of the clinic altogether) for my own research.

Because I settled into a trusted position relatively quickly in these small, un-institutional settings, I was treated almost like a staff member, even before I came into contact with any clients. When I did begin interviewing clients, I was shown, in two of the centres, to the filing cabinets where the clinical notes were kept. Once I had been referred to a client (usually through their therapist, but always in communication with them or the clinical manager), I was able to access their details through their clinical notes. This was to find out basic information like their country of origin, age, referrer and so on, but this was often followed directly by referrer notes about their previous assessments and life experiences. As well as this, many of the therapists were keen to discuss the person with me before I met them. There was an ethics to this: knowing what someone's background is, their experiences, and other clinicians' assessments of their need allowed me to think through how I could most sensitively relate to them in interviews.<sup>26</sup> But it was also about being interested, curious to "know" what someone has been through, what their encounters with care providers have been like. Funders increasingly called for "human interest" stories to demonstrate the need for and impact of particular services. Therapists too were interested in these kinds of stories: one told me that discussions about clinical assessments were something akin to gossip, albeit "professional gossip," as she showed me a new assessment form that was being introduced to that centre. She told me this as testament to how fascinating therapists found it to talk about people's lives. In whose *interest* was this kind of curiosity and knowledge sharing? There is an implicit assumption (whether or not it is always fulfilled) that a therapist's knowledge about a case is obtained and shared in the "best interests of the client," given their role as a provider of care and healing. This is not the role of the researcher, however—a researcher must not harm, but they are not there to heal.

I quickly became uncomfortable with entering into dialogue with someone for the first time, having had access to information they did not choose to share with me. It seemed to load yet more control on the researcher in (what can be) an already grossly imbalanced power dynamic between researcher and researched. Curiously, it was the

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<sup>26</sup> A good example of the ethics of being told someone's clinical history was when I was told that a young man I was about to interview had a form of autism and had come to the centre after being unable to access a therapy service especially for young people with special needs. Knowing this diagnosis influenced how I engaged with him during the interview in very simple ways—allowing me to let him take the lead when it came to physical proximity and shaking hands, for example.

*expectation* from clients that I would know all about their experiences, rather than any suspicion or withholding of information that amplified my discomfort about knowing this information. One interaction in particular springs to mind, where I had been uncomfortable knowing about a client's deeply violent and traumatic pre-migration experiences, which she had only relatively recently shared with a professional for the first time. Her therapist had told me about these experiences but had not told the client that this information had been shared. I had been left in the yet more uncomfortable position of having to respond to the disclosure, unsure about whether I "should" know about her experiences or not. I came to think that perhaps *her interests* were less about "not being in distress" and more about having control over where her story travelled and with whom she wished to share it.

Experiences like this moved me to refrain from looking at people's clinical notes before I interviewed them, to develop ways to limit what therapists told me about clients to essential information about how vulnerable they were at that particular stage of the therapy, and to be up front with clients about the information that had and had not been shared. I did this, not to be "neutral" but rather to be honest about whose interests this information was serving, and think through where my interests—to obtain data and maintain a sense of control and responsibility within the interviews—were in danger of superseding the interests of the person I was interviewing. And so the practice of sharing information—whether between therapists or, on occasion, between therapist and ethnographer—was only acceptable when it was "in the client's best interests." This was a judgement that had to be made with what Jeannette Pols has called "contextual reflexivity": a moral sensitivity to specific persons and situations (Pols 2006). The judgement depended on my role in those particular (non-NHS, though still clinical) settings and the differences in vested interests between myself and the other actors involved.

### *Becoming affected*

A final way of becoming interested, which perhaps brings these different meanings—of finding the world or subject under study, “out there” interesting, and developing one’s own vested interests in this world—is the idea of becoming *affected* by that world. Since in my work I do not engage with affect theory as such, and nor do I foreground affective or emotional processes in my methodology, I want to use this term in a fairly narrow sense: to talk about how over time, my interest in my field sites came to be about being moved by and sensitised to differences, discontinuities and unexpected aspects of the practices I observed and participated in. In the text I quoted above, this has been described as “being affected by differences” (Latour 2004a, 210). Being involved in the everyday rhythm of organisations gave me a sense of their lived ordinary and sensitised me to moments that were out of the ordinary. I recorded these in my field notes to be read back in the context of my reflections on a much larger temporal scale.

These moments often became central to my analysis and writing up of the ethnographic material, not just because they stood alone as being interesting, but because I felt that I had become affected by them in the much broader context of my fieldwork. Take the anecdote about dumping and tidying that comes up in Chapter 4: the story was in a sense isolated, *outside* the doors of the service, and yet it illuminated something to me about the on-going practices around dumping and tidying that went on *inside* the service. Or the ruptures that were created by being forced to move building or having a clinical space encroached upon by having to sell or rent out rooms: these took place at particular moments in time (experienced by me either first hand or through hearing stories of these moments), but they were constant reference points. They cast light on the precarity of these organisations, which would otherwise remain abstract and knowable only through rumours or an understanding of the organisations’ (projected) financial situations. From these reference points, I was able to sense when things became more or less precarious, noticing people’s changing spatial and affective interactions with the “the outside” (be this mainstream services, potential clients, or the physical outside space) and the (dis)continuities in how people looked after the inside space.

This on-going process of becoming affected also helped me to work with absence and presence when it came to asking questions about how “need” was being enacted day-to-day. In chapter 7, I describe how “diagnoses” are neither completely absent nor present, but an “absent presence” (Law and Mol 2001), constantly being made absent but always kept firmly in view. This analysis was possible only through observing many instances of therapists and clients grappling with diagnostic labels and pinpointing moments where the work of treating need *non*-diagnostically held particular risks or possibilities. In the process of making sense of how and why needs were enacted in different *places* (as opposed to what I have just described in terms of different *moments*), being affected involved an attunement to the kind of labour it took to treat and manage “need” as eligibility criteria for the service. As I bring out in Chapter 8 (and more implicitly throughout the thesis), this manifested in a kind of “labour of inclusion”<sup>27</sup> which was common across my field sites: people were much more concerned with producing eligibility and inclusion than they were with exclusion. However, the way in which need and eligibility criteria was enacted played out in very different ways, and so this labour manifested itself differently across places. As such, becoming sensitive to difference required on-going movement and comparison across “cases,” which (as I have alluded to above) shifted between “the case” of the whole consortium of voluntary organisations, of each particular place, and of particular ethnographic encounters.

## **II. Mapping and Tracing**

From very early on in the project, I was interested in spatial and material aspects of accessing and providing access to mental health care. Not in measuring distances from homes to services, or the geographical accessibility of places, but in studying “moments of access” (White, Hillman, and Latimer 2012), which were situated around, and on either side of, the “doors” to the service, and which could lead to insights into (particularly first-time) encounters with particular mental health services. During the fieldwork, I developed part of my methodology around mapping and tracing “place” within my three field sites. In particular, the thresholds, entrance

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<sup>27</sup> This “labour of inclusion” could be seen as a kind of flip-side to, and mirroring of, Latimer’s “labour of division” in hospitals (Latimer 1998).

points, and first encounters with these sites, which I was getting my bearings of through the research process. I chose to analyse “place” as an “*instantaneous configuration of positions*” (as Michel de Certeau (1984) describes the concept), rather than the much-explored notion of “the therapeutic space” in the field of psychotherapy (for example, the work of Wilfred Bion, as explored in Bondi 2005b). I see place as a product of space and spatial practices, and therefore refer to “spatial” aspects of the accounts I describe gathering in this section. However, I came to understand place as *constantly in production* and never a fixed or stable product, as might be suggested by separating out space and place in this way. My argument echoes Ingold’s insistence that “life unfolds, not in places but along paths...places are then delineated by movement” (2009, 34).

The mapping and tracing of place that I describe in this section can be seen as both a method and a methodology: a *method*, in that it was a device<sup>28</sup> for map-making and analysis; and as a *methodology* in that it comprises the “placing” part of this “*placing need*” methodology I am building in this chapter. Before describing the “nuts and bolts” of what I did to develop and perform this device, I will briefly describe my rationale for developing it, with reference to both theoretical material and some early ethnographic experiences that led me to the notion of *placing*.

### *Placing and “surfacing”*

What was it that impelled me to follow this analytical thread of *placing*? I will start with the data. Before I actively elicited spatial stories from the people I spoke to—quite literally making places visible through mapping techniques—I became attuned to the salience of place through more informal interactions. A common narrative when I would ask about what made these voluntary clinics special or different to the mainstream was that they were physically less municipal and institutional than NHS buildings. But this independence from statutory services was a double-edged sword: the following scene took place early on in my fieldwork, when I was familiarising

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<sup>28</sup> I use this notion of method as “device” in the same way as Lury and Wakeford (2012), who locate their notion of device in relation to that of [Foucault’s] “apparatus,” which helps make clear that a device or method is never able to operate in isolation. The authors contributing to the volume are said to “destabilize any sense that a device—even when it is a thing—is merely a tool, able to be used always and everywhere in the same way.”

myself with the first setting I became embedded in and had found myself a companion to do so with.

It is the end of the working day and getting late; the therapists have mostly filtered out, and although there were no windows in the room we are working in, I can sense the evening closing in as the fluorescent lights continue to glare overhead. I am talking with a senior therapist who has also only recently started working at the centre. She has been working huge amounts of overtime to get to grips with the place and the many people who pass in and out of these small therapy rooms to receive or deliver therapy in their fifty-minute slots. We are exchanging notes on our first impressions of the centre. This new therapist is worried about the space they're working in: the lack of windows and noise levels in the centre, which she feels gets in the way of it being a "therapeutic space". In a way, she is shocked by the place, because it gives her the impression that the organisation mirrors the client group; "the poverty of the building seems to reflect the position of the minority groups it is supposed to serve", she says. We talk about who this "client group" is: the different migration patterns that bring an ever-changing flow of cultures and nationalities into the centre, but also, the influence of other charities in the area, who they have partnered with, sharing the referrals and specialised responsibilities for one of the boroughs they serve. She suspects that they are all in "survival mode" too—not only following the need in the community, but also following the funding. As charities, she says, leaning in ever so slightly, they are all constantly responding to the context in which they work; this is what they all have to do to survive.

I was interested in what this therapist said about the place reflecting the position of the people it served—an astute analysis, coming of course, from a trained analyst of associations and metaphors. But it did not feel adequate to take this as a given, or just analyse it as metaphor. In other contexts too, I became aware of ways in which these states of survival or precarity, as I go on to talk about in Chapter 6, could become metaphors for the centres themselves, or vice versa—perhaps the centres are metaphors for the conditions of the people. Either way, I wanted to explore how these metaphors and materialities were coming into being and how they related to spatial practices of accessing, entering, gatekeeping and so on. In other words, how were places coming into being?

My gravitation towards analysing people's interactions with thresholds and boundaries of the centres did more than just tell me about people's first impressions of the buildings, or the kind of literal or spatial obstacles they may have had "accessing" services. It was telling me something about how these places were coming into being, in a process that echoes the way Janelle Taylor (2005, 745) talks about bodies being "made and remade through practice" in her work on "surfacing the body interior." *Surfacing* is a framing device that Taylor develops in order to push back against an anthropological tendency to study "objects" that pre-exist the ethnography, and instead to explore how bodily surfaces *materialise*. She is influenced here by Butler's ideas about "matter" as a process of materialisation over time "to produce the effect of boundary, fixity, and surface we call matter" (Butler 2011, 9) and her work resonates with others who have theorised the processual becoming of bodies and matter (Barad 2003; Ahmed 2004). My methodology extends this idea to services, and the surfaces or thresholds that make them materialise into places to access, and to be included or excluded from.<sup>29</sup> Surfacing, in Taylor's generous exploration of the term, is also about *making visible*: of bringing to the surface what had been submerged. The following section explains how I developed a method for generating visual data, in order to bring practices and experiences of place to light, *but also* to allow the making and remaking of surfaces, thresholds, and boundaries to continue, through the image-making and my analysis of this unfolding.

### *Place-making*

Interviewing service users and providers about how they accessed or facilitated access to care was central to the way I gathered data in the field (details of which I expand on below). However, fairly quickly it became clear that the verbal or textual data they generated would only take me so far. In order to orient the interviews to *practices* and *places* (what they "make and remake", in the words of Taylor (2005)), it was necessary to develop a means for me, as an ethnographer, to (re)engage people with their past interactions and practices within these particular places. I employed a creative interview method of visual mapping, which has been framed as a device to help research participants to communicate and discuss experiences that are difficult to articulate in words (Gauntlett and Holzwarth 2006; Literat 2013; Bagnoli 2009), and

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<sup>29</sup> This speaks to a broader theoretical approach to "ontological politics" in which all realities are "made and remade" (Law 2004).

specifically, experiences of a spatial and material nature (Powell 2010; McGrath and Reavey 2013; Knowles and Sweetman 2004). In the context of my project, I used visual mapping to generate data about the process of accessing each psychotherapy centre (for clients)<sup>30</sup> and for facilitating this process (for staff). More broadly, the creative interviews offered an alternative “way in” to specific fragments of narratives around accessing care, which some people (mainly clients who were new migrants) were tired of articulating and repeating for various professionals and authorities in terms of clinical pathways, or in order to demonstrate their eligibility for free services.

In contrast to many of the scholars who use mapping or creative methods to understand experiences in a phenomenological sense (Seamon 2000), or to more fully understand people’s whole narratives or perspectives (Literat 2013), I wanted to treat access as a set of practices or a “happening,” part of a narrative fragment capturing the encounter between person and place. So, rather than asking clients about what they “felt” or “how they experienced” their first encounter with the services, I’d asked them to draw a map of the centre focusing on first impressions and memories *what happened* when they accessed the service as a new client. For staff, this was less straightforward, because I quickly noticed that they witnessed and participated in the process of clients entering the service (sometimes for the first time) multiple times each week, or even day, allowing the material aspects of place and its *surfaces* to “disappear from view” (as Ahmed (2004) has talked about in terms of the surfaces of the body). But I nevertheless strived to elicit accounts of “what happens when you encounter a new client who is entering this space.”

I developed McGrath and Reavey’s (2013) method of asking people to draw a map of a mental health setting as a means to “elicit space-focussed accounts from participants” (ibid., p.125). The function of mapping, then, was a means to elicit and analyse live accounts of encounters with place, rather than fixed “representations” of a setting. This speaks to a commitment (discussed above) to consider both places and ways of being as constantly *in the making*. As such, the isolated sections of the maps I reproduce in my data chapters serve only to be illustrative of the images being

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<sup>30</sup> It also worked well in interviews conducted in English with people for whom this was not their first language; all of the people I conducted these creative interviews were comfortable enough to speak to me in English, but several had opted to speak in a different language for therapy, suggesting the inevitable limits of language would be further amplified in these encounters.

generated during the mapping and should not in themselves be viewed as fixed “products”. The “product” (if you can call it that), is multiple and on-going: a series of spatial accounts made and re-made in the world I was studying, and of course, inhabiting alongside the service users and providers I was working with.

### *Tracing and re-tracing*

Representation, as my argument so far has echoed, “is not a neutral tool” (Law and Singleton 2003, 5). I kept this maxim close as I gathered, recorded and analysed all the different accounts of place, thinking through the assumptions and the limits of each way of telling or showing. For example, when someone would draw themselves entering the clinic, rather than describe it in words, I would not assume that this is any closer to their “real” experience. I would however note that this medium has *different* possibilities and limitations, and expects a different kind of account. As I describe below, the most interesting data was generated when these visual mediums failed and people had to switch, giving up on drawing, or even on talking. I also treated my own recordings and analyses of these accounts as non-representational, and rather, as a way of co-producing the places that I write about in this thesis. Tracing<sup>31</sup> became a useful way to think about these accounts, and of being accountable for them. The first “tracing” took place when people re-traced their own movements through space and provided commentary in their various ways. I would keep the original maps (or “tracings”) in tact, making use of tracing paper to lay over the images and annotate them, charting (literally by number) how they were produced moment-by-moment. This tracing produced a new story, which *I* was then accountable for and used to analyse and then write my own ethnographic accounts of the image-making. These in turn fed into my broader analyses of emergent themes from my ethnographic work. I attend to this below, when I outline my analytical approach. Here, however, I would like to dwell on some of the “productive failures” of this method of working to generate visual data.<sup>32</sup>

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<sup>31</sup> I try not to theorise this notion of tracing too much, as it comes with much baggage, for example, Deleuze and Guattari’s insistence that rhizomatic, non-representational thinking must be “a map and not a tracing” (Deleuze and Guattari 1988, 12). Instead I use it as a fairly pragmatic tool, embedded in my own conceptual framing that I have been building throughout this chapter.

<sup>32</sup> These instances demonstrate of Wakeford and Lury’s (2012, 4) claim that inventive method can “enable research to follow forked directions, to trace processes that are in disequilibrium or uncertain, to acknowledge and refract complex combinations of human and non-human agencies”

Often some of the most interesting material would be invisible in the image itself. This “material” could be made manifest only through ethnographic accounts of their making. The process would oftentimes involve moments where the medium of visual representation broke down completely or became inadequate. I bring this out explicitly in Chapter 6, where the woman I was interviewing allowed her commentary of the map to surpass the making of it, abandoning the drawing of the waiting room she had been doing but remaining in the spatial plane, and dynamically playing out the interactions she was having with both people and things. This performance was overlaid on the tracing paper in numbered notes, written directly after the interview and then later analysed, and written up in prose (see Chapter 6 for this ethnographic description, embedded within a broader analysis). I saw this more embodied telling of spatial experiences with others, too. A therapist, whom I had known for many months before interviewing her, was somehow bemused and impatient with the mapping—she had lots to tell me about the routine of creating a sense of welcome and calm for her clients but the mapping offered little more than a prompt. “Soon, her pen leaves the paper,” I wrote in my field notes, “and she starts to physically show me how she wants to present herself to the client.” What I want to highlight here is that there was nothing intrinsic or special about the “visual-ness” of the maps, which made the data they produced interesting and generative. It was that they offered a way out of purely lingual, linear lines of question and answering, inviting people to think spontaneously about moments of access in terms of their spatial, embodied or material features.

Another person, who happened to be an actor and writer by trade, hesitantly sketched what looked like a very chaotic spatial story of the centre, but his on-going commentary was full of carefully crafted metaphors (“a cascade of images, associations and memories that his hand couldn’t keep up with, and I end up simply listening to,” as I reproduce in Chapter 4). Others found the maps brought up blanks in their memories, leaving them unable to depict specific things, or much at all. A young woman who had experienced extreme violence before accessing the Women’s Centre had little attention or memory for her surroundings:

“Yeah it [my body] feels dead when I’m sitting in that chair, I don’t mind who’s there [she gestures to the chair next to her— one of the big pistachio ones next to her so she can kind of act it out, looking away from the empty chair and gesturing

with her hands either side of her eyes like blinkers...] I could even be waiting there with someone, but I don't even see them.”

It was these “failures” of representation that helped me think productively about the myriad of ways places are produced and “things” and “surfaces” get made present or absent. Doubts, blanks and inaccuracies (my own as well as my interlocutors’) pushed this yet further, in way that speaks to Micheal Taussig’s fascination with drawing as “more than the result of seeing. It is a seeing that doubts itself, and beyond that, doubts the world of man” (2011, 2).

### **III. Writing: recording, analysing and performing**

I have been describing different elements of my ethnographic methodology, exploring aspects of my “being there” in the field, and specifically, in terms of *becoming interested*. I have also attended to the first of two broad aspects of my methodological approach: *mapping and tracing* place, which can be understood in terms of the conceptual idea I have been developing in the thesis of *placing need*. The final part of this chapter deals with my ethnographic approach to recording and analysing and producing knowledge about the practices I observed, primarily in answer to my questions about how “need” is enacted in these settings. This is where I describe the bulk of methods that enabled me to produce this piece of “ethnography,” which, Tim Ingold reminds us, “quite literally, means *writing about the people*” (Ingold 2014, 385). In reference to this, I structure my descriptions of all the rest of my methodological practices around writing practices: practices of textually *recording* my observations, interviews and other forms of data gathering; practices of *analysing* this data (as well as the data I have described in the sections above) through coding, creating analytical frameworks and generating ideas; and finally, practices of *forming and performing* ideas through writing ethnographic scenes, writing experimentally, and writing analytically. This is not intended to separate the writing from the other practices I have been describing in this chapter, but rather, to frame it as an adjunct practice, which was going on alongside them, iteratively, but ultimately the medium through which all of these practices were transformed into knowledge.

### *Writing to record*

As I have described above, a large part of my “being” in my field sites was enabled through volunteering and participating in the work and social lives of the centres. Some of these interactions would find their way into written field notes, typed in Word documents after the event, in the strange process of transforming what had been informal and shared into private analytical notes. But I also spent countless hours as a not-so-participatory observer of the more professional practices located in the centres and connected spaces in the community: observing meetings; recruiting clients (which involved a huge amount of waiting, hanging around and missing people, as well as interacting with staff and clients as a researcher); shadowing clinical managers, community development therapists and link workers in and out of the centres; being in the background of organisational events such as AGMs, conferences, presentations, trainings; observing reflective therapeutic sessions with staff members; observing the induction of new trainee therapists; and, of course, the kind of “hanging out” that involved working in the administrative spaces and observing all the bureaucratic, day-to-day work of the permanent staff, and the comings and goings of all the many volunteer, honorary and part-time staff. Perhaps the richest source of data (and certainly the most consistent) on clinical practices was the referral, assessment and allocation meetings, for which in one centre (and, more sporadically, in a second) I was tasked with the role of minute-taker, formalising my practice of constantly hand-writing notes in meetings. All of these notes could be taken in a much more continuous, live way than the typed ones—often as they unfolded in real time—in what Emerson, Fretz, and Shaw (2011) call “scratch notes.”

I would later type these handwritten scratch notes into more coherent narratives, with a column down the side for analytical notes, and later, for coding. Similarly, I transcribed the formal interviews that were audio-recorded and typed up those which weren't from notes written during or directly after the interview. But the half-dozen or more notebooks I filled with handwritten notes from observations and interviews ended up being my most vital source for ethnographic writing. I would often bypass the typed, analysed documents, marvelling at the immediacy of the handwriting: how they bore the temporality of moments unfolding—sometimes rushed, almost illegible, other times visibly drawn out and adorned with signs of boredom. Then of course

there were the direct quotes, scribbled down urgently, parts emphatically underlined. Seeing the shape of these notes and how they were arranged across the page transported me back to the space and I could attach bodily movements or voices to these words in a way that I was utterly unable to do from the typed notes.

I later made sense of this through reading Ingold's reflections on "taking a line for a walk": the way that "knowledge is integrated along a path of movement" in handwritten text, just like a line of walking (2006, 31). I found this particularly acute when I was tracing (in the method I have described above) parts of the interview maps that contained words, written as annotations by the interviewee. I wrote the following memo (about the analysis of the mapping that I talk about in Chapter 4) about the perspective of a client, whom I call Claire, on what was emerging as one of many iterations of the "dump" metaphor:

I noticed that there was a big difference between tracing over someone's lines that represent objects and space, and tracing over someone's handwriting, particularly when those words are direct memories as they are articulated about the experience. There is something more removed about the lines of the map, as they are an imagined picture of something that is far away from where we are and external to the person (re)creating them. And so, strangely, words have an immediacy to them that the images don't. I find as I trace over the small, rounded but sometimes loopy handwriting of C, I feel uncomfortably close to the emotion she was feeling. It was much more sensory to simultaneously read and overlay the words: "little ally, dank, dirty, smelly, small, empty, no idea if someone was waiting in bins/bushes, no one would see you"... than it was to see the visual representation of cartoony bins and bushes and barbed wire fence in a wobbly criss-cross in pencil. It seems to me like it is coming directly out of their head and onto the page.

I am now less interested in how directly I was able to access people's "inner experiences," or even my own inner thoughts at those moments of revisiting handwritten text. Rather, I take from this the possibility of recognising the *embodied movements* captured in the handwritten responses from different actors at these moments. Attending to text as traces of movement transformed events into ways of *knowing* people and their surroundings. This reflects how ethnographic ways of

knowing develop by participating in, and moving through the world (Ingold 2006; de Certeau 1984).

### *Writing to analyse*

My aim with each method of analysis was to make it as generative as possible, across the fieldwork and writing process. In order to form more overarching themes and arguments, I worked mainly from the typed field notes and transcripts I have been describing. I moved through these texts, open coding<sup>33</sup> and writing memos in the margins to bring out and generate broader themes for possible development. Although I did not follow a process of open, axial and theoretical coding of grounded theory, I call this initial process “coding” to demonstrate how it generated themes and ideas that could span or travel across cases. I also used the “gerund” approach advocated by Charmaz (2012) which builds practices and action into codes, assuming that these codes are *made* rather than *found*. I developed the more inductive, overarching, “horizontal” ideas by building “outwards” from key questions or ideas (e.g. “assessing need”) or spatial locations (e.g. “the waiting room” or individual centres). I would do this by mind-mapping key practices and themes that I had been developing, and building more detail and connections from across data sources, noting from whom and where they arose.<sup>34</sup>

If this coding and mind-mapping worked as a kind of “horizontal” working across places and people, I also created narrative summaries at the end of each interview, starting several sentences with “this is a story about...,” in order to think “vertically” through people’s stories, maintaining them as whole events. As I worked through different forms of data, these vertical and horizontal ways of thinking became useful for different things. Because I encountered client stories in discrete one-to-one encounters, each with their own particular context and background, I found it useful to keep a record of these whole interactions and come back to them once I had

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<sup>33</sup> I did not use NVivo software for coding (preferring to mark the typed notes and create post-it notes of key themes for indexing), however, I did use the software as a data management tool to save and organise all of my textual data according to site and type of informant (service user or provider) and to enable word searches and other queries. As such, I “borrowed” tools and techniques I had developed previously in more formulaic qualitative analysis methods.

<sup>34</sup> This is similar to the One Sheet of Paper approach (Ziebland and McPherson 2006; Pope, Ziebland, and Mays 2000), but departs from these authors in that it does not aim for comprehensiveness (noting “all the different issues”), and rather for building connections or imaginative leaps between moments and data sources around places and themes.

developed more fully formed themes and arguments from the rest of the data, which was more embedded in the shared clinical contexts of my field sites. I would then consider individual stories in relation to key analytical ideas to interrogate how they might manifest themselves differently for different people, and why. An example can be seen in Chapter 7 where I had taken the broad theme of “making diagnoses absent” and thought through the exact risks and possibilities of this in one particular client story. Similarly, I pushed my analysis forward by re-visiting the fragments of these narratives that were produced through visual mapping by developing a set of analytical questions to “ask” the visual data (Mason 2010), creating textual accounts based on theoretical ideas and my own themes as they developed (see appendix 1 for the questions I developed for this analytical technique). It was this dynamic movement between different types of data and analytical ideas that helped me generate and make choices about the broad concepts that I build my chapters around.

### *Writing to form and perform*

I write this section, on the practice of writing to form and perform knowledge, as a conclusion to this chapter. Yet paradoxically, I want to make the point that my methodology, based around this concept of *placing need*, is characterised by *unfinished-ness*, and makes space for indeterminacy. In this way, I echo the voice of the “paper boat collective”<sup>35</sup> when they argue that ethnographic writing is in a sense something to be cast away, something which may not always return us to the world that occasioned it, and that may not have the last word on what everything means or how it should be acted on (Pandian and McLean 2017). My writing about place, as I have been describing, has been all about capturing entities *in-the making*: for example, describing processes rather than products of place-making or mapping. But this conceptual unfinished-ness is also evident in my chapters on “need,” where I used the writing to make sense of the ways that different forms of need were made absent or present across sites. Although we anthropologists are trained to always ask “how” rather than “what” questions, I became fixated on what need *is* and how individual needs were *determined* in my field sites. This remained frustratingly difficult to

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<sup>35</sup>This collective comprises the writers of a text on literary anthropology, arising from a weeklong seminar hosted by the School for Advanced Research, in the same location that the Clifford and Marcus’ (1986) *writing culture* text was conceived of 30 years previously.

understand from interviews and observations, where as I describe in Chapters 7 and 8, I could glean so much more about what therapists and clients were resisting or making absent, than how they *did* choose to articulate and enact need. It was through my writing of ethnographic scenes of tension or debate in clinical decision-making that I began to develop my findings on how need was *negotiated* and the *indeterminacies* of need.

This process of writing, then, was generative and illuminating, but it never provided me with clear answers to questions such as “if not diagnosis, then what?” in assessment practices for needs and eligibility. This example is testament to Kirin Narayan’s assurance that “the process of writing inevitably brings discoveries,” even when (particularly in ethnographic writing) it refuses to bring answers or conclusions (Narayan 2012, 2). Throughout the process of writing, I experimented with different forms and devices to push forward my thinking and analysis, and to think about ways of analysing the data “otherwise.” For example, I wrote and re-wrote text in the form of blog posts, then as short stories, and anecdotes, which I then embedded into much broader arguments. The anecdote is an example of how stories can become generative, contributing to how the social world is both understood and produced (Micheal 2014). In these ways, and many more, my ethnographic writing worked to perform my analyses of, and *in*, the social world I inhabited. The performativity of the writing itself helped to bring my key concepts, *place* and *need*, and the relations between the two, into being.

## PART ONE: PLACE

## **Introduction to Part One**

In this part of the thesis, my ethnographic material unfolds at three bounded but institutionally connected places. In each chapter, I explore socio-material aspects of accessing and providing access to a particular psychotherapeutic space, visiting each centre in turn. Although the centres are geographically close (a walk or a bus ride between them), I treat them discretely; as organisational entities and, crucially, products of the spatial practices and place-making that I observed in each one. I explore “place” mainly at the level of the building, though I also talk of these care providers as positioned or “placed” in the landscape of the city and the health and social care system. And so, the spatial practices of service users and providers also play out at different scales. A theme running through all of the sites was the instability and insecurity of material places in the voluntary sector, where funding only ever covered contracts for the day-to-day delivery of short-term talking therapy. I chart the implications of this frustrating set-up, which seemed to assume that voluntary sector services like these somehow floated in space, without the need for shelter, electricity, heating, let alone the kind of furnishing and other items that most people agreed was necessary for a “therapeutic space.”

Place is of course also significant in the context of migration, which I have talked about being intimately connected to issues of access to care. For example, immigration status can be the criteria for inclusion or exclusion to certain institutions or services. These experiences and a specific concern for the exclusion of non-citizens in mainstream care emerged strongly in the data, in part because it featured in the personal narratives of many of the service users and providers I encountered, but also because this concern was increasingly becoming a point of mobilisation of support and resources in public health narratives about “unmet need.” This pattern unfolds in the course of the chapters through it is not immediately visible, deliberately complicating the notion that this “unmet need” pre-exists “out there” and can be unproblematically attached to a specific social group. I have been guided by provocations (described in the literature review) to look at the ways in which identity, subjectivity and belonging to certain social categories can be a question of *where* you are, as well as what you *do*, rather than simply “being” a certain “kind” of person or

service user. As such, my starting point is place and practices of place-making, and I do not do not come to the topic of migration until about half way through these three chapters. Themes of movement, inclusion, exclusion, bordering and belonging, and out-of-placeness, run through all the way through them, but do not immediately concern the large-scale mobility that I have covered in the literature above, or speak to larger ideas in this thesis about the migration as a global “matter of concern.”

I start with Chapter 4 to talk about place and access in terms of the making and managing of exteriority through the talk and work of “dumping” in the everyday life of the Stepping Stones service. Then, in Chapter 5, I move on to talking about the similarly on-going, processual set of practices around the maintenance of *interiority*: of places of sanctuary in therapy, particularly in the Pankhurst Women’s Centre. It is here, through the deliberate practices of “reaching out” to an expanding potential client group and more dispersed and potentially fluid notions of sanctuary, that I land on the theme of migrant lives and the categories and conditions associated with this. Finally, in Chapter 6, I follow this theme to the final site, Culture in Mind, where migration and migrant lives become more central to the argument I make about the enactment of place and precarity.

## Chapter 4: No dumping!

“No Dumping!” says the makeshift sign, imploringly hand-painted directly onto the wall of the cul-de-sac, where the Stepping Stones counselling service is based. The sign is much needed here, as there are no rubbish collections. The land is privately owned and everyone rents off one man, who rarely sees the place, and certainly doesn’t carry out the day-to-day work that is needed to maintain areas that the public infrastructure doesn’t reach. But, despite its size and hefty underline, the sign can’t do all the work either: full bin bags regularly appear outside the service and along the narrow street, which staff normally pick up and take to the road’s end, past the threshold for the bin men. There are also abandoned cars that line the street, rusting, and—resting on soft tires—threaten to sink into the tarmac below. Although we’ve all stopped seeing them ages ago, they press into the already narrow space outside the doors of the service, making it feel crowded. And so I notice, as I haul a black plastic bag past the cars and round the bend of the narrow street, how much *happens* in the absence of a usually invisible infrastructure of public space; what grows, encroaches and accumulates in a street like this.

I am joining at the tail end of a big clear up of the cul-de-sac, the result of some feedback that had come up in my interviews with new clients at the service. My reports of people’s misgivings about the place as they had first approached it had impelled the staff at the centre, headed by Sian and her partner, Alex, to spend a few days doing more than their usual tidying up around the edges of the centre, and get the place looking really welcoming for their clients. Apparently, once they had started doing some of the more visible bits, lots of the neighbours had chipped in with cleaning up some of the detritus that had built up over the years. They had been pleased with what they had achieved and now there was talk of how they would maintain the work they had done together. Sian said that she and Alex were toying with the idea of erecting some gates down at the entrance to the cul-de-sac, where it meets the high street, to try and keep people who weren’t residents or clients from coming in to the space.

The bin bag I am carrying is full of old painting materials and cut back weeds that had crept along the length of the wall. The sign has been redone and the blue and white board looks crisp and colourful. The wall, too, has been painted. It used to be red brick like the house, but Alex did it white a few days ago. I think it looks quite good, but as we walk past Sian points to it, commenting that it’s already really dirty.

There is quite a lot of black creeping up from the ground, which I guess is inevitable with cars coming in and out, churning up the grime from the uneven cobblestones. As we wander back, I notice that they have rigged up a plastic creeper all the way along the silver fencing on the side of the alleyway. The leaves are a dull green colour, a little too blue, too uniformly shaped, to be convincing, but it does the job. Although it never really disturbed me, the metal fencing in itself had been a bit grim, especially with the uneven wire extending the height at the top. It shields us from the back-end of the police station, and, behind that, the multi-story grey building, which now stands derelict. Now, the plastic ivy covers the fence for about two meters and then stops, so although you can see through to the other side if you want to, your attention is drawn to the foreground and towards the sign that points you to the centre.

Back in the office of the centre, I strike up conversation with Sian about how the community had got involved in the clear-up. The most important thing someone did was clear up this ‘corner’ that everyone had been refusing to go anywhere near. She told me this whilst carrying on with her emails, only taking her eyes off the screen to glance at me to gauge my reaction, or to squeeze her eyes shut and grimace as she described the nasty bits. In the slight enclave next to the police-station fencing, she says, was a corner which someone had basically been using as a toilet. There was a huge pile of excrement there and no one had had the courage to tackle it. Shocked at her assumption that it was a human ‘someone,’ I ask her why she didn’t think it was just a dog or a fox. She reminds me of a story I’d heard before about the homeless people that used to sleep and hang around in the cul-de-sac, saying that she suspects they might be coming back now that summer is approaching and the nights are warmer. In the end, Sian said, she thought it was the neighbour from over the back wall who had tackled the worst of it and that all that was left to do now was sluice some bleachy water through it and hope it stays clean. I peek sideways at “the corner” as I leave later; there’s not much to see now, save four plastic ivy “leaves” that have blown off the fence and are stuck there, intact.

This scene took place outside the Stepping Stones counselling service; the place I have described as being for anyone struggling to cope with the pain of bereavement, rather than for a specific population, or for a particular diagnosable condition. The “anyone” is important here, as it starts this story with a care provider that is both specialised and “counter” to the mainstream model of mental health care, and yet—

unlike my other two field sites—serves the needs of no specific “client group.” The flexibility and inclusivity that the Stepping Stones model embraced both defined the service and took constant and careful work to maintain. *Maintenance* and *tidying up* were, then, themes that sat easily within this narrative. But, as the scene above unfolded, some time into my fieldwork at this site, I noticed that several stories and ethnographic moments had begun to coalesce around a somewhat unexpected and more uncomfortable theme of *dumping*. The scene illuminates several components of dumping practices and spaces, which both speak for themselves *and* to a broad metaphor that was evoked within several of my field sites. This, I discovered, had to do with the challenges of working in the centres, and of managing the incoming flows of people from various iterations of “the outside.” In this chapter, I explore how interiority and exteriority (as well as inclusion and exclusion; the mainstream and the marginal) are enacted and reinforced by the talk and work of dumping.

What were these components of dumping spaces and dumping practices that I allude to above? In this very material iteration of “the outside,” some of the objects in that street weren’t necessarily waste, but rather, a kind of *overflow* from the city around it. Without knowing the abandoned cars had been there for the past six months or so, they would simply blend in with the other cars, squashed in and lining the areas they could fit, hiding from the expensive inner-city parking costs and overcrowded roadsides. There was also an element of *concealment* in the way that the cars and other objects tended to be somewhat surreptitiously placed and left there; it was a place where unsightly or prohibited things could be kept out of sight of most of the public and those authorities that might take issue with them. There was also the *displacement*, which had caused the homeless people that Sian described come to the site in the first place; they too were a prohibited presence in many of the publicly owned and patrolled spaces around the centre. Finally, and most starkly reminiscent of the *waste and contamination* of the dump, was the corner of excrement that was presumed to come from these elusive homeless men and had to be managed with buckets of bleach and, if possible, not approached at all.

## Chapter overview

In the section below, I will use these different components and associations with dumping (dumping grounds, overflow, concealment, displacement, and even waste and contamination) as a way into exploring how the metaphor was used in one field site. I focus first on the inside space before coming back to the outside scene above, narrating the events leading up to it. What these events amount to is a slightly odd story that does not (on its own) represent the normal happenings within this centre, or indeed the other sites I conducted fieldwork in. However, it introduces a particular happening—a story of matter out of place (Douglas 1966/2013) *and* people out of place (Ahmed 2000) that tells us something important about how dumping and dumping grounds get enacted, both metaphorically and materially, in the landscape of mental health services in this context. It could be described in the words of Lauren Berlant (referencing Susan Leigh Star’s ethnographies of infrastructure) as a “glitch of the present”: a unique happening that serves as “a revelation of what had been the lived ordinary” (Berlant 2015, 403). In other words, it was a happening that occurred in isolation to all of the ordinary dilemmas of access and belonging, but nevertheless can be seen within a wider assemblage of comings and goings that give a different perspective on how these therapeutic places are made and re-made, and for whom.

Throughout the chapter, I seek to demonstrate how multiple relations are central to the material and discursive practices of boundary making, and of clearing and displacing. Following the section on metaphors of dumping *inside* the service, I turn to the material traces of dumping that could be found *outside* the doors of the service, using the pile of excrement I describe in the vignette above as a starting point. I trace this object back to a story, which, in its telling and retelling by various actors (including myself), became what Mike Michael has called “anecdotalized” (2014). That is, it became generative of how the social world is both understood and produced. I will then I seek to disrupt and find *chips in the inside/ outside logic* (of the metaphors of dumping inside, next to the materialities of dumping outside) by taking a closer look at the ethnographic moments that unfold at, or move the threshold between, inside and outside; belonging and non-belonging. Ultimately, I make the case that the “dump” is characterised not by the “waste” that fills it, but what the

“dump” is exterior *to* and the relations that define this. This has important implications for how we understand the paradox these service providers found themselves facing: that the “tidying up,” of both matter out-of-place *and people out-of-place* was a constant enactment of the organisation’s position in the health and social care system: of being always, almost *on the outside*.

### **Metaphors of the dump: *Inside***

Of all the spatial metaphors that arose in the day-to-day talk about providing access to care across the sites I was working in (bridges, sanctuaries, holding spaces, safe places, etcetera), this one carried with it the most varied, and often troubled, meanings and associations. The metaphor of voluntary organisations as “dumping grounds,” and referral practices as “dumping,” spoke broadly to the fear that these services will become (or are becoming) unfairly overburdened in a climate of overcrowded or non-existent services in the statutory mental health care system. But the imagery of the dumping ground and its associations with dumping, overflow, concealment, displacement, and even waste and contamination, holds together a complex picture of how providers of care understand this problem to be playing out, and how they are constantly managing and responding to it.

These metaphors must then be handled carefully, not least because of their strong connotations with carelessness and stigma— both highly charged terms in the world of mental health services, and terms that in many ways would be unhelpful and unfair to bring too centrally into the narratives of these particular spaces. And yet it is the peripheral that I am interested in: what remains on the threshold, or is only just kept at bay; that which perhaps came about by accident, outside of the intended function of these spaces. Throughout this section, I will focus on the ways in which this set of issues is articulated, often through peripheral conversations or small talk from the sidelines. This is not to overemphasise problems that may be secondary to more pressing concerns for the providers of these services, but rather to think with them about these peripheral but persistent ideas, which they often raised but would not usually have the time or space to dwell on. Using elements from the scene above,

I will break down this unwieldy metaphor into the more tangible themes, outlined above, of dumping grounds, overflow, concealment, displacement, and waste.

*Dumping ground, displacement, overflow, concealment and waste*

*Dumping ground:* The first time I had heard the phrase “dumping ground” was in fact in a different centre, when the politics of referral patterns were being explained to me. I was told that “the voluntary sector is being seen as a ‘dumping ground’”: *somewhere* to “put” people with nowhere else to go, rather than a resource or provider of specialised services. The phrase was met with a quiet wince from the director of that organisation, who tried to more carefully rephrase the narrative, without disagreeing with it. It came up several times more, often also followed by a reflection or caveat, but with a similar sense of unguarded, spontaneous anger at this ugly new development:

Back at the Stepping Stones centre, inside the building now: Sara is standing in the doorway of the office before her client arrives for their therapy session. She is telling me how people who get referred by mainstream services always seem to be more likely to miss appointments than those who self-refer. But there’s something else she wants to get off her chest. She hesitates, then: “these *people* who get sent here from other services, it’s the people they can’t deal with, or they don’t know what to do with. They’re so difficult, they are cases that are not meant for here; this one woman I see, she’s totally psychotic! Well we’re finishing now, but I have another and she’s also very paranoid, very skittish, it’s so hard to work with her. People give them to me because I’m ‘more experienced’- well some of them have been working for 20-30 years!”

“I guess you’re more qualified than most of the volunteers though, no?” I say, trying to put her predicament in a slightly better light for her, perhaps in order to placate her obvious anger about it.

“OK yeah, but just because I’m accredited and all that. I can’t deal with it any better than the rest. They’ve been really tricky.” She turns to leave finally, but lingers, saying after a pause: “You know, this place is a dumping ground, I’m telling you. It’s a dumping ground for these other services...”

*Displacement:* No longer able to work solely with people that she was sure had made an informed decision to refer themselves to the service, Sara’s discomfort seemed

broadly to be about how little control she had over who she would be seeing and when. She was charging other services with irresponsibly placing (“dumping”) people with Stepping Stones, when they would be better helped somewhere else. Often, I would learn later, these very tricky cases would come from crisis houses: short term residential settings for people suffering from acute mental distress at a given time. Like the IAPT services, they were also oversubscribed, with the added pressure of widespread closure and cuts, which the longer-running members of staff talked about seeing over the years. People would come after being discharged from the crisis houses, having received a period of support but often still very vulnerable. Others seemed to have been referred to the service in the absence of much needed longer-term health and social care. One woman came in for an assessment, without really being sure what she was there for, because—I was told afterwards—she had learning difficulties as well as the mental distress she was experiencing from a recent loss. This hadn’t been on her referral notes and she had come to the centre alone. The receptionist recounted how she had been able to see the woman’s discomfort and confusion as soon as she came in, and that she was uncomfortable that they had even gone ahead with the assessment as she had lost control of her bladder in the therapy room. The receptionist told me with an apologetic look in her eyes that “she just didn’t belong here.”

*Overflow:* As I go on to show, staff at all the centres I worked with were all too aware of how full and overworked the NHS Improving Access to Psychological Therapies (IAPT) services were, and how much more stringent their inclusion criteria were than voluntary organisations. The IAPT remit to work with “common mental disorders,” restricted to particular “clusters” of low level mental health needs, meant that they needed to refer on many people with more severe or complex needs. Although voluntary organisations are also encouraged to adopt the same “clustering” system, the therapists I spent time with were often reticent to stick too strictly to the system, given the different commitments they had to ensuring that people from the communities they served weren’t left with “nowhere else to go”. These specific inclusion criteria of NHS IAPT services, coupled with high (and continually rising) demand for talking therapies in the general population, created a sense that these services were *overflowing* with people whose needs they were unable to meet.

*Concealment:* Dumping, particularly when associated with a specific out-of-the-way or unseen place, has a strong association with concealment: putting what should not be seen, out of sight. It was in the Stepping Stones service that I heard this aspect of the dumping metaphor the most, perhaps because its broad inclusion criteria created opportunities for referrers to slip people in when unable to find space elsewhere, or perhaps it was something to do with its physical location. I asked Gail, one of the long-standing administrators at the service, about the fact that I had heard people talking about clients being dumped here; was this something she recognised? She responded by playing out the following familiar scenario, showing me how she imagined these kinds of decisions get made behind the scenes at the doctors' surgeries:

“Well in the flurry before August they're all going on holiday” she says. “Oh it'll be— ‘what on earth do I do with this one? I've been sitting on this client for weeks and weeks, I've got to do something,’ Then the client'll go: ‘Errrr, my father died seven years ago,’ ... ‘Right OK, we'll refer you to Stepping Stones for some bereavement counselling,’ they'll say.”

Gail said all of this with a knowing laugh, almost enjoying the fact that they could see through these professionals' surreptitious, slightly sneaky tactics to move a client on to somewhere they could be both out of sight and out of mind. This low-level but continual influx of individuals coming in for the wrong reason framed the problem in more benign terms than I had been used to hearing, but it carried similarly uncomfortable connotations with disposal practices. If the influx through the IAPT channels conjured images of a large-scale dumping operation, these practices were those of fly-tippers: deliberate, opportunistic, furtively dodging the rules.

*Waste:* As I became aware of the discourses associated with dumping, I started to think tentatively about what this said or implied about the objects of the metaphorical dump. *Waste* was a strong theme in the way that people talked about how ineffectual it was referring people who wouldn't turn up, because they are unwilling or unable to make it to regular therapy sessions. Although staff were unsurprised and generally understanding about people who “DNA'ed” (Did Not Attend), there were strict rules in all three centres to try to minimise wasted time and resources on these people. It was a case of two DNA's for an assessment, and you

would lose your place on the waiting list. Administrators were less tolerant of this wasted time than the volunteer counsellors, who were conscious of their clients' chaotic lives and—a common trope in therapeutic practice—considered the time still “theirs” even if they could not be present. Gail and Julie were much more aware of the precious time wasted on these people that could have gone to others. Then there were the costs of processing each case, which could not be included in the targets for the funders so would not be covered by the contracts. Core resources of administrative time and costs of therapeutic assessments would therefore be transformed into waste.

### **Materialities: *Outside***

The everyday work and “tidying up” that staff engaged in to maintain the area outside the doors of the service reflected the inherently peripheral positioning of the organisation in the broader landscape of care. Alongside the ethos of volunteerism and independent, not-for-profit care, came an uneasy reliance on the mainstream for resources and financial survival. This had become particularly acute since their funding had been scaled back, and was now concentrated in a few contracts with the NHS. These contracts covered the costs of service provision but not core costs, such as rent. The service had not always been in the cul-de-sac; in fact, Stepping Stones had moved a few years before from a big Georgian house close by, which was subsequently sold off and renovated. They had moved to this space with the approval of some (mainly management and trustees) and to the dismay of others (mainly staff and therapists), who missed the homeliness of the old place and couldn't shake the knowledge that the building had been designed for offices and not therapeutic activities. Those who were most upset about the move left because of it, and some who stayed talked of the old house being not just built on and repurposed but “demolished”. Occupying this privately owned, and always potentially transitory, site, made the service's position as *always almost-on-the-outside* of this central institution particularly visible.

Interestingly, when I came to investigate clients' encounters with the place through visual mapping interviews, much of what was produced and talked about by service

users remained outside the doors of the centre. All of the clients I had interviewed at that point had focussed in on their vivid sensory memories of their approach to the service, with the cul-de-sac often dominating the maps they had produced. Like Alex, who had offered to erect a new set of gates at the entrance to the cul-de-sac, they were compelled to draw their own boundaries of the place, which reached beyond the front doors of the service into the small hinterland that joined the building to the busy high street. Several people emphasised, through their images and commentary on their movement through the space, the difference between the dark outside and light inside: emerging into a place characterised by plants, light and homeliness.

Claire, a young woman I had met in the centre just after her initial assessment session was a good example of a person who distinctly *did* belong. Ralph, the therapist who assessed Claire, had introduced me to her, telling me afterwards that she was his first “loss” client—the first person he was taking on under the newly expanded inclusion criteria for the low-cost service. In addition to their contracted work, via the NHS, to provide therapy for people struggling with bereavement, they started charging what they described as an affordable rate for anyone who could be described as having experienced “loss” in their lives. Claire had been offered this, partly because her borough had recently cut their contract to deliver bereavement therapy to its residents, and partly because her story was *not*, in fact, about death. The brain injury Claire’s husband suffered had made him into a completely different entity— one that she said, “replaced his old self”— but he was still alive, having recently left an intensive care unit for a more long term care home. She had been waiting to see a counsellor on the NHS for almost two years after the accident that had left her shocked and mistrustful of healthcare settings. Beyond the new emergency departments that her husband was initially rushed into after the accident, she recalled, she’d been appalled by the conditions of the NHS hospital wards; she remembered with a shudder going into a treatment room and seeing the previous patient’s blood on the walls. When I met up with her again, it was in a café closer to her home, where we chatted over herbal teas before starting the recorded interview.

## *Mapping: Claire*

12<sup>th</sup> April 2017

In a café close to Claire's house

For a short moment, Claire is hesitant with putting the pencil she is using to paper; she has only been to the service once before, and she is not sure which way the road bends around. Fairly quickly, however, she seems to stop being concerned with this, making it a simple right-angle and focussing instead on what she remembers sensing at this point. Silently, she makes a list of descriptors:

“little ally

dank

dirty

smelly

small entry

no exit.”

Then she constructs the criss-cross of the wire fence along the last edge of the ally she has outlined, saying she remembers there being a fence somewhere (later, she will add barbed wire to this when she talks about thinking she might be in the wrong place and almost deciding to turn back). She layers the sign in front of the fencing, calling it “dodgy” and writing “clinic” on it. She starts to give it a label saying it was “falling down” but then puts a line through “falling” as she visualises it and remembers that it wasn't actually broken. She writes, “dishevelled” next to it instead. Then she goes back to her list of sensory descriptions around the entry point to the street from the open space at the bottom of the page that she has labelled “main road”. She adds to the list, saying the words slowly as they appear in joined-up handwriting on the page: “no idea if someone was waiting in the bins/ bushes. No one would see you.” She returns to the space in which she had drawn the sign and fence, adding two cloud shapes, which she labels “bushes” and two equally sized squares with little circles for wheels, which are the “dumpsters” she feared could hide the ambusher. I ask what time this all was, and she writes “11 am Saturday” underneath everything. Then, as she follows her pathway back through the ally, she reminisces about the smell, writing and commenting that it smelled like an “after party”, making us both laugh. Quickly, however, she moves back to the right angle bend, which reminds her how out of sight she would be from the main road; her tone sobers again as she reflects on what an easy spot it would be for someone to grab her with no one seeing or hearing anything from the main road.

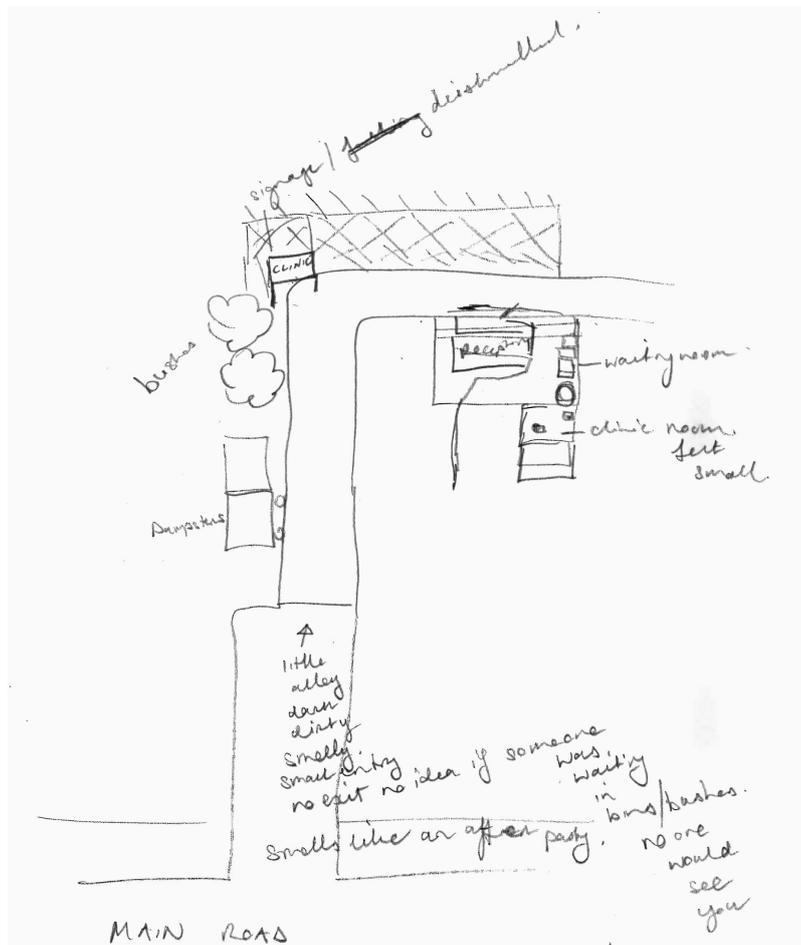


Figure 1: Claire's map

Even after the abysmal experiences she had had with the health and social care system before she even got to Stepping Stones (“Oh God, here we go, another brick wall”), coming to see the assessment here was the first time that Claire had really been able to communicate how her distress was affecting her. Although she had eventually been put at ease by the light, and cleanliness (and of course the interactions she had with the receptionist and then Ralph) inside the centre, her response had been particularly visceral to the outside space. It communicated to me something very real about the way her distress was interacting with the material environment she was entering into. Her fear of the dirty clinic was deeply connected to her past experiences of her partner’s care (or lack thereof) and she made clear she was not prepared to let herself be drawn into another place of disorder and neglect.

## **The trace of the human, in anecdotes**

Shortly after this interview with Claire took place, Sian wanted me to share some early findings in an upcoming board meeting. As I recounted this to the board of trustees and management of the service, amongst the tea and biscuits and homemade rock cakes, they listened intently, their faces tired and concerned. I knew they'd worked hard at making this a place of solace for their clients, so it felt important, although somewhat uncomfortable, to share these particular fragments of these clients' narratives. I hoped it didn't sound like I was trying to move the goalposts; to tell them they were now completely responsible, with their tiny budget, for their clients' experiences in the spaces beyond the doors of their service. I described this to them as diplomatically as I could, alongside the positive experiences that everyone had as soon as they stepped inside the centre and emphasising how glad Claire had been just to be listened to by her assessor. Although she would have to pay a small fee for this new loss service, I relayed her relief at not having her needs scrutinised or challenged, or being put on another indefinite waiting list

When I finished talking, however, it was the imaginary man in the bushes that seemed to have captured everyone's attention. One of the board members informed me that in fact this wasn't so far from the truth, that there *had* in fact, last year, been two men hanging around outside the service. There were sighs as they collectively reminisced about how difficult it had been to get rid of the men, and debated a little about where they ended up. The first version of the story, that "someone had given them a house," didn't seem to hold, but they couldn't agree or remember what else could have done the trick. The main thing, the chair explained, was that they were no longer there to upset any vulnerable clients coming to the service. She made eye contact with me as she said the word "vulnerable," signalling to me that Claire's story had been taken seriously, that her vulnerability was something that they were accountable for.

Although Claire's fears had nothing to do with these particular men, there was no doubt that she *was* vulnerable and that the threat (real or imagined) of encountering strangers in this space was heightening the fears and anxieties that had brought her to the service in the first place. This was completely in line with what I had taken

away from our interview and was sharing in the meeting. In contrast to the board of trustees, the clinicians in the room were in fact just as interested in the fact that the man Claire was afraid of, and the bushes that he might jump out of, in fact *weren't* real. The cul-de-sac she described had no bushes on the ground, and there was only one bin in the place of the two dumpsters she had mapped out from memory. Sian explained to us that Claire was projecting her fears about past and future healthcare experiences into her field of peripheral vision, and so could not bring herself to see what was really there; her map was one of her inner world. And so even if the man and the bushes were part of Claire's imagination, there was something undoubtedly real about her vulnerability and its relation to the space she was describing and constructing.

When the trustees brought up their memory of the two men (who became strangely synonymous with Claire's imaginary man in the dumpster) I realised that they were part of a story that had been humming along in the background at the service since I'd arrived. Mostly it had been a vague jumble of anecdotes about some homeless people who had been sleeping in the doorway of the service long before I had started volunteering there: there was the mention from the receptionist that one of the pair had popped up in the Tesco's car park a few streets away, astonished that she'd recognised him ("I think he thought he was invisible!"); then sometimes people would talk about the "night revellers" that used to leave glass bottles whose broken shards would shine in the gutters; and, of course, there were the traces of human presence that during the clear-up had stuck with everyone much more than the abandoned cars or rubbish bags had.

From what I gathered, a member of the trustees had discovered the two figures with their sleeping bags and cans scattered around them, when she came in for a board meeting one morning. She had decided that without someone personally intervening, it was likely they would get settled there. There were concerns that they were being aggressive and would scare the clients, if not actually hurt them, if the two men were left to use the entrance area of the centre as a base for sleeping and hanging out in. It remained unclear from what the longer standing members of staff told me whether the fears about the homeless duo's aggression ever actually played out. Jill described them in benign—although rather euphemistic—terms, saying several times that they

“weren’t lovable,” gently explaining how they had unhygienic habits of “making a mess” peeing outside, or sleeping with their dog lying between them. Others were more hostile. One of the volunteer counsellors, in a conversation in the corridor, wanted me to know that he didn’t believe they were homeless at all. He called them “street drinkers,” dropping a tone to tell me that they were also “*Romanian folk*,” as if that said enough. Julie, one of the administrators, said that despite not being very nice to look at, they never actually did anything to the centre or to any of the clients.

In the end, these variations in the stories were fairly inconsequential, as the trustees and management quickly agreed that the men needed to go. Ironically, it was Julie (who was the most sympathetic and least intimidated by the men) that they enlisted to call the police in the hope that they would resolve the situation. Apparently, the police had been resistant to coming in and intervening, partly because (according to Julie) they just had better things to be doing, but also because it was not automatically their responsibility, as the street was privately owned land rather than public space. She told me about this looking out sideways from behind her computer monitor, an elbow on the desk, looking defiant. She hadn’t wanted to call the police; her conviction was “either you help people with your whole heart, with generosity, or you just leave them be.” But they kept asking, and she didn’t think they would be interested in her opinion. So she kept calling, until they were gone. I never found out exactly how the men were removed, or persuaded to move on to, but they were not seen at the service again. Except, of course, for the matter in the corner that, according to Sian, meant they could be back for the summer.

And so, like much of this story, the shit remained shrouded in mystery; I never discovered who or what it came from (there was no such trace of the men when I returned to visit some months later), or whether it would become a kind of warning signal that they would be back. Despite being something of an anomaly, it made quite an impression on us all, and it quickly got connected to other happenings in the space. Not only was it was unhygienic, it was assumed to come from a human: a human who—by virtue of them leaving such a trace— should not have been there. The taboo, it seemed, came from a very particular combination of the toxicity of waste, and the out-of-place person.

## **The relationality of the dump: A chip in the inside-outside logic**

What is becoming clear from the ethnographic material generated from both inside and outside of the centre is that dumping is relational and contingent on what has come to pass, and for whom, in particular sites. If I was becoming seduced by the idea that the relationality of dumping and waste was somehow a singular relation between centre and periphery—in this case, the mainstream and the voluntary sector—this was soon punctured by clients’ accounts of their travels in and out of a multitude of different care settings, each with their own means and shortcomings in keeping at bay the unmanageable and the uninvited. Neil, an astute and energetic man in his sixties, was in the throes of not only grieving his adult daughter’s death, but in fighting a legal battle against the mental health services that he believed were responsible for it. And so his was a story about someone else’s mental healthcare as much as it was about his own. It was in his journeys through the NHS, voluntary, and private spheres with his daughter, Leonie, that he felt he had found where the ‘real’ waste and toxicity of the system ultimately lay.

### *Mapping: Neil*

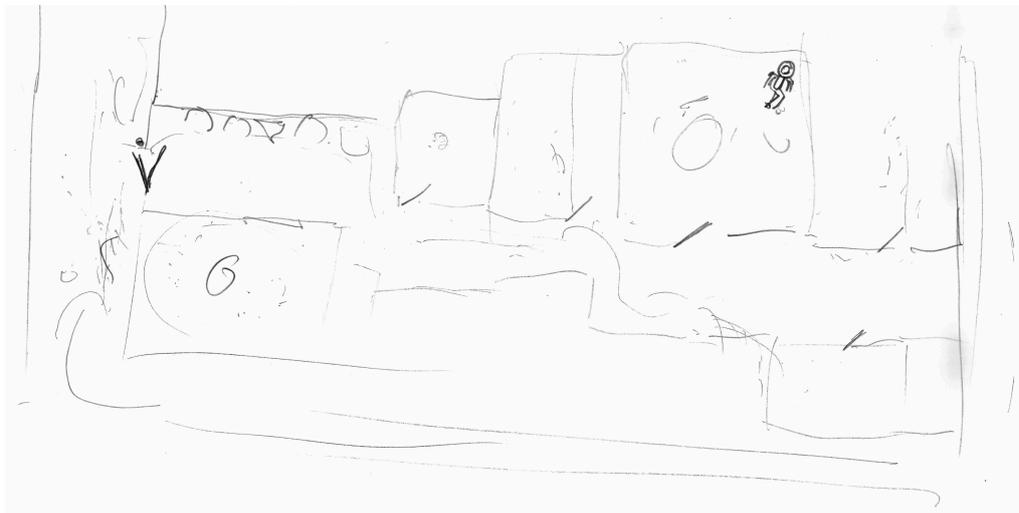
28<sup>th</sup> March 2017

A therapy room at Stepping Stones

We are looking down at the rough bird’s eye view plan of the space that Neil had produced, each line a chaotic rope of light pencil strokes where he had absent mindedly continued to reiterate sections as he looked up to explain in words what he could only begin to suggest on the paper. He is a storyteller (an actor and writer) by trade, and representing his immediate surroundings like this brings a cascade of images, associations and memories that his hand can’t keep up with, and I end up simply listening to. The set-up of the service reminds him somehow of a start-up business- “you come across them in a number of buildings, you know, down on canals and things where they’ve done them up...” He riffs off this idea, describing the slightly DIY, transitory feeling the space gives off, and comparing it to the different kinds of care settings he has encountered. Despite its lack of physical stature, he “quite likes” the feeling here; there is real warmth and fondness to these slightly unflattering descriptions of our surroundings. Although an ardent supporter

of the NHS, he struggles with the impersonal municipality of it, remembering being dwarfed by the gigantic hospital where he'd had to identify his daughter's body. Considering where people would generally want to be when dealing with such devastation and "screwed up emotions," he appreciates being somewhere smaller.

And yet, it was the neatness and exclusivity of some of the other spaces he had encountered that Neil seems most alienated by. He rails against the consulting rooms and residential care settings of some of the private providers he had gone to with Leonie over the years. It was these places that evoked in him the deepest sense of mistrust, where he came to see the interiors as "crap around the place trying to make you feel as though you're important" whilst in fact symbolising the money that they were taking from you for the privilege of being there. In the end, he had had little to do with his daughter's decision to admit herself to a private clinic that provided residential care for people living with long term mental illness, but he can recall his misgivings about the place. The way they had done it up, he says, was trying to make it look as though everything was going smoothly, when really it wasn't doing its job at all. Just "shine on the shit," he calls it, looking back down at his feathered pencil strokes and saying resolutely, "yeah, I quite like the feeling here, actually."



**Figure 2: A fragment of Neil's map**

I include this encounter as a reminder that, as Mary Douglas has told us in no uncertain terms: "there is no such thing as absolute dirt: it exists in the eye of the

beholder” (1966/2013, 2)<sup>36</sup>. Neil saw the centre as something he wanted to be part of, a place that was on the right side of what he knew to be a deeply politicised landscape of different kinds of care. Despite his deep ethical allegiance to the NHS, he could no longer feel quite at ease with vastness and impersonal nature of the places in which he’d experienced the worst of his emotional pain. But it was *private* clinics that were really the “wrong side of the tracks” for him. His distain for the politics of private healthcare had been amplified into a visceral sense of repulsion, after its failure to protect his daughter from her illness. Illuminating the function of dumping as concealment I touched on at the beginning of this chapter, Neil’s accusation of putting “shine on the shit,” tells us that this was a particularly insidious form of dirt and disorder, one that was obscured and covered up, in contrast to the diligent— if not always entirely effective— tidying up that went on at Stepping Stones. The remaining untidiness was not nearly as worrisome as the *false* cleanliness he recalled from the private sector; in fact, it appeared somewhat friendly, and helped to produce the interiority and intimacy that made him feel cared for.

### *The making and managing of exteriority*

Abstract dichotomies of “inside” and “outside” were beginning to collapse in on themselves around the doors of the Stepping Stones counselling service. The first, and seemingly most obvious, distinction between what goes on inside and outside of the organisation itself quickly got blurry, largely because of how implicated the outside space was in the client experiences of accessing the service. It emerged in the everyday work that staff engaged in to maintain broader space outside of the walls of the building, and the way that it reflected the broader financial and structural positioning of the organisation as a voluntary provider of care. This was something that came into focus in the scene I opened with: Alex’s aspiration to build another set of gates at the end of the cul-de-sac was a clear demonstration that the boundary between inside and outside could be redefined, and there was an impetus to do so in recognition of the impact the outdoor space had on how people experienced the organisation and the service itself. Indeed, most people in their mapping of the space

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<sup>36</sup> Neil’s response complicates Douglas’s idea that “dirt is essentially disorder” (ibid.): in this instance he *likes* the seeming aesthetic disorder, as much as he hates the false neatness of the private sector. What others may see as ‘dirt/disorder’ Neil experiences as containing and orderly, whereas that which masquerades as order, he experiences as deeply untrustworthy. What is “in place” and “out of place” is constantly shifting according to different relational orders.

used the line where the un-even, partly cobbled and partly tarmacked street met the smooth pavement of the high street as the outermost point of their map. This extension of the physical boundary of the service was— although not part of the clinical work— very much a part of the practices around accepting bodies into the space or diverting them away from it.

What all of these stories were illustrating was that whilst the voluntary space of the clinic never actually materialised as a literal *dumping ground*, it was true that its positioning outside of the main infrastructure of the city meant that this was always a possibility. Its tucked-away locale within a busy and rapidly changing urban milieu, with no public maintenance, made it vulnerable to the encroaching waste from fly-tippers and lazy neighbours. With my descriptions of this, I have been trying to demonstrate that the making of interiority and exteriority is the result of many different relations, and not always under the control of any one actor: managing where the dump is, and what constitutes the “outside,” is not always as easy as moving the gate.

And so indeed, the themes of ‘matter out of place’ *outside* the service, and ‘people out of place’ *inside* the service start to collapse somewhat. Some bodies carry with them, and leave traces of, more unwelcome physical waste than do other bodies. This is more likely to be the homeless body than the one contained by a home (the home being key to accessing many public services); but it is also the more severely mentally unwell body. Take the instance described by Sara in the first section, of the woman who “just didn’t belong here”. Here, because of the learning difficulties that seemed to have gone unnoticed or uncared for, she had become visibly and viscerally out of place when she peed on herself in the therapy room. I had probably heard about this particular woman because of this visibility, and how narrate-able her story then became. The very rare decision *not* to take someone on for therapy once they had made it in for an assessment was made, was based not just on mental health status, but also someone’s embodied presence in the space.

Considering the ways in which unwanted matter is deeply connected to bodies raises yet another question about where the dumping ground lies. The centre itself occasionally bears the marks of unsuitable guests— of *people out of place*— because of

the failures of other parts of the welfare or health and social care system. But, more often than not, it is these people that bear the marks of such failures; having mental illness that has been uncared for, or indeed being without a place to live and criminalised for sleeping rough, at some point becomes visible on the bodies of those who live out these realities. In a way, it is these people – as much as the built environment, organisational structures, or voluntary staff – that are being “dumped on.” Dirt was doing its work inside the service, and on bodies too: the inside/ outside, metaphor/ material, body/ place divides were emerging as something of a red herring. There was a recursivity to the making of exteriority through dumping, meaning it doesn’t just happen on one scale, or even between two scales (I have already spoken now about the complex relations between the body, the organisation, the mainstream health and social care system, and society at large). It would be better described as a practice that was both *relational* and that *took place at multiple scales*: between the NHS and voluntary organisations, between public and private space, between society and individual bodies, and so on.

### **Conclusions: The lived ordinary, on the periphery**

So much of the work that I observed here, and in other voluntary settings, was defined by an exteriority to the mainstream. But, crucially, this exteriority is constantly produced or reproduced by spatial politics and relations— meaning it is never absolute. I have been trying to challenge a seemingly obvious distinction between the scenes on the intrusion of physical waste, and those on the discursive practice of using the dumping metaphor: that the former were focused on happenings “on the outside,” whilst the latter were about all about the normal organisational practices inside the service. Looked at another way, they are *all* peripheral happenings, taking place at various points along and increasingly blurry inside-outside continuum.

As they unfolded, the ethnographic moments I have explored here—of the clear-up, Claire’s first encounter with the centre, and the storytelling about the homeless men— were brought together almost by accident: a triggered memory here, a suspicion there, often with many months in between. But for me, the linkages are

potentially more intimately connected and interesting than this. They revealed something of the *lived ordinary* of managing access to service, access that is in multiple ways on the periphery of a broader landscape of care. Juxtaposing Claire's position as the kind of client who without a doubt belonged in the service, with the homeless men as imposters on the space, sets up an unusual comparison. The men were a strange kind of inversion of the normal practice, because they weren't just an exception to the rule, they existed entirely outside of the rules. They weren't being turned away due to clinical inclusion or exclusion criteria for counselling. They were, in Berlant's words, "a glitch in the present": a device, which made visible the *on-going work* it takes to make and maintain a certain kind of space for people to access the service with an ever-broadening spectrum of need.

In a climate of scarcity and trade-offs in space, resources, and time in the health and social care system, it becomes all the more necessary to manage and protect the boundaries of small services like this one. This holds, even as (or perhaps *particularly* as) the therapeutic care is supposed to be open to "anybody." This speaks to Taylor's commentary on "surfaces," which I touched upon earlier; on the "dynamic tension" between producing and performing surfaces whilst *also* breaching them (Taylor 2005). Put differently, making outer boundaries more porous or "breach-able" can mean (and in this case, did mean) more work of fixing and re-making these boundaries and others. Staff and clients at Stepping Stones were occupied with this work in response to a multitude of possibilities and challenges associated with surviving whilst constantly being *almost on the outside*. This chapter, then, has been all about making and managing *exteriority*; in the next chapter, on "sanctuary," I address related questions on the management of *interiority*.

## Chapter 5: Sanctuary Under Siege

Shortly after my starting to work with the Pankhurst Women's Centre, clinical work is put on hold for the day and the therapy rooms are all vacated. A large conference has been organised to celebrate the "birthday" of the organisation and the decades of work that have passed since its opening. We are in an elegantly designed lecture theatre: red brick, clad with curved wooden panels and simple black lamps hanging in lines overhead, leading our gaze to the lectern and a large projector screen. We are being addressed by a tall woman with silver hair, and she is showing us her silk scarf; purple and white—the colours of women's suffrage. She too is excited by the place we are gathered in, going on to tell us why it has a special "poetic significance" for all of us here. It is the former site of the Women's Library, which had recently been at the centre of a bitter struggle that ended in its dislocation from this purpose-built space. Many of the women in the room, she tells us, were involved in this struggle. She doesn't dwell on this further, swiftly moving on to her forthcoming book and the line-up for the day's events, but I am interested in this story, and later look up what exactly had happened.

Online newspaper articles from 2014 tell me that a historical archive of books, magazines, letters and documentation of feminist activism had been brought to this site twelve years ago, after a precarious existence; first in a converted pub, and later (after that was bombed during WW2) in what was then known as City of London Polytechnic. It had found its new home in the old washrooms of London's East End, which the Lottery Heritage Fund had transformed into this sanctuary for both advocates of the women's movement and its material artefacts. The library was run by what became London Metropolitan University, until the lottery money ran out and the university found itself financially overstretched and struggling to maintain it. Eventually, they declared it untenable to keep running the library in the space and another wealthier university won the rights to be the collection's new guardians. Notwithstanding the outrage of academics and campaigners who lamented the inaccessible, overly academic nature of the new space, it was announced that the collection had been "saved" and the converted washrooms became a flexible event space, rented out for occasions like this. In one interview I came across online, a campaigner (an architect) described the now redundant custom-made shelves and lighting system as a body without its insides.

It is hard to shake the frustrating combination of nostalgia and disappointment that hangs in the air of this event space; it emanates not just from the spectre of the failed library campaign, but from the gulf that lies between the ideals set out by some of these women all those years ago, and the reality of what they are seeing play out today. We have just witnessed Donald Trump come into power in the U.S., and the second wave feminism that was the driving force behind the centre at its inception has bafflingly disappeared from sight for the generation of women who fill the room today. The founders of the centre, both eminent academics who have long since moved on from their roles as grass-roots feminist psychotherapists, are initially faithful to the organisers' hope that today will be about celebration. They tell us of how they came together all those years ago to change women's lives and to change the world. Very soon, however, they are also forced to be candid about the state of this ambition, at a time when many of the women helping to realise it are now volunteers, working in the face of dwindling resources.

“Look, here's the thing: we failed,” one of them says with dramatic sincerity in response to the dissatisfaction being voiced in the final panel. She is talking in the broadest sense about the original project of second-wave feminism, of changing the world unequivocally. But she is also talking of her *own* project, of *their own* project, which has (successfully or not) shape-shifted into something recognisable but smaller and less clearly defined than it had once been. She goes on to make an analogy about mothers and grandmothers and their (often difficult) relationships with their daughters; her eloquence softens the collective disquiet—faint hostility, even—that still hangs in the room. And yet I would discover later the very specific ways in which her words speak to the experiences of the new generation of women I went on to work with. They have not been protected and supported in this new, hostile environment where they have been forced to “scrabble around” for funding and resources. In another sense, they are not concerned with the preservation of records and work-gone-by, as many of the women who had formerly been involved with the centre were; they are too busy making it work, day-to-day. I would soon learn that the conference had told me little about this everyday practice, but lots about these layers of previous lives that had unfolded over the recent past, not to mention the bitter tensions this had brought with it.

This chapter focuses on the provision and protection of safe therapeutic places for women, and the changing priorities and debates about whom (*which women*) they

should include, contain, and reach. As such, it will also pay close attention to particular moments of tension, failure or fragmentation—echoing those described above—which threaten the ongoing project of the Women’s Centre. It will be about the constant tension between the desire to preserve and contain, and the need to shape-shift and reach beyond the bounds of an increasingly precarious therapeutic space at this particular centre. Drawing on the discursive ways in which the centre has been described historically, as well as more immediate spatial observations and accounts from my own fieldwork, I use the concept of *sanctuary* to pull together themes of safety, protection, preservation, and (at times) orthodoxy, which seemed to be at the heart of many of these struggles to establish and continue the work of this particular charity.

I ground the ethnographic material in the (loss of) physical space of the centre, as well as extensions of this space that came about through the outreach work that was set up to reach more marginal and mobile groups of women. About halfway through this chapter, the turn from specific outreach work to migrant, refugee and asylum seeking women becomes central, as does the need to create a place of sanctuary in *different ways* for these groups. But throughout the chapter, I also draw on a different kind of spatiality, to help analyse why the work of these women was so plagued with controversy, and understand the feelings of failure articulated in the scene described above. This alternative spatiality is grounded in topological ideas of fluidity versus immutability (Law and Mol 2001, 1995; Law 2003): the idea that as well as Euclidean space, there is a network space, in which complex sets of relations hold objects together or, indeed, let them fall apart. Whilst sometimes these networks remain immutable and fixed, others are fluid, opening up the possibility of gradual movement and adaptation (Redfield 2016; De Laet and Mol 2000). In this chapter, I enquire about the nature of sanctuary as an object in this context: how it is shaped, both in Euclidean space (the literal changing borders and boundaries around the centre as a place of sanctuary) and the topological space of more fixed or more fluid relations that make up different versions of sanctuary.

My argument rests on the idea that objects are shaped by processes (Stenner 2014), and that the processes I observed throughout my time at the centre were not just about holding together a coherent and safe space; they were *also* about processes of

shrinkage, fragmentation, dilution and mobility. These processes were often considered to be threats to what the centre should be, or once had been, which is why I have used the phrase “sanctuary under siege” as a descriptor for how those invested in the centre perceived the (spatial) politics that took place around it. What I aim to bring out in the ethnographic data is that these processes of change—threatening failure and articulated as “being under siege”—*are paradoxically what define sanctuary* in this context. To take a very different example of how this might happen, one might think about the function and symbolism of a lifeboat: it represents safety and preservation of life far more than a cruise ship, despite the fact that one is more likely to drown, fall overboard, or get immersed by water if you are on a lifeboat. It is the processes of disaster and rescue that define it as safe. I am interested in the ways in which processes of dilution and fragmentation, as well as more obvious processes of containment and protection, might work together to define “sanctuary” as a surprisingly nebulous object in this setting.

## **Chapter overview**

I start with sketching a picture of the small therapy space that is valued by service users and providers alike as a fairly fixed and bounded set of rooms, which lives up to an aesthetic and sensory ideal of sanctuary. However, by attending to the recent history of the place (focusing on moments of its making and unmaking), I draw out the first of several ways this ideal of sanctuary has been seen to be under threat: through the *encroachment* of more dominant mainstream or private psychotherapy services, which have been buying up and occupying the spaces around them. I then explore a very different, community based approach to providing places of safety for vulnerable and excluded women— one that in recent years has become central to the centre’s strategy for improving the accessibility of their service, but not without contestation. The historical but still lingering pushback against taking psychotherapy out of the consulting room and into “the community” will bring me to a second set of processes in which a traditional mode of sanctuary has been threatened: through its *dilution* and *fragmentation*. Central to all of these processes, it is the concern for imminent falling apart or failure of the project to make and preserve this sanctuary (harking back the talk of failure that had troubled the conference I described above,

and which troubled me deeply in the writing about these processes). In a closing section, I talk about an alternative process I observed, which by no means solves the problems I described above, but which offers a more mobile and fluid version of the work of inclusion.

### **Sensing sanctuary**

When Siobhan, one of the volunteer therapists, needed to come to the centre briefly one afternoon over the school holidays, she brought her son and daughter in with her. Peeking into one of the empty therapy rooms, they had fallen silent, taking in the stillness and the carefully placed furniture.

“It’s very holy,” her son had whispered, making Siobhan smile. She knew what he’d meant: not exactly churchlike, but calm, and safe. I did too. I rarely spent time in the one-to-one therapy rooms, but when I did use them for interviews, I was always struck upon entering the space by something you might call holiness. Most had windows facing west so that, in the afternoons, low sun would stream in and illuminate the very particular configuration of low-set chairs, table (tissues and clock positioned on top) and lamp. For me, there was something untouchable about this space; if I cleared the table to make space for a Dictaphone or paper to draw on, I would feel as though I may be disrupting something irrevocably. Perhaps I was fearful that if I wasn’t able to place it back exactly, the ritual that had been and was about to come to pass would be somehow disturbed.

Siobhan recalled this memory when I asked her about the centre as a space and what she thought people felt about it. Apart from the amusement this naïve insight brought with it, she used it to animate the point she was making: that people tended to feel the centre to be a place of safety. Compared to some of the places that her clients talked about having sought help from in the past, it seemed particularly lovely: “they all say ‘oh you’ve got such a nice place!’” Siobhan echoed back to me, from her clients’ reactions. I had also found that certain women, whom I knew had experienced particularly unwelcoming or frightening mental health settings, seemed impressed with the softly coloured decor, the paintings, the patterned rugs covering the more municipal-style carpet. This was of course all deliberate; Abiola, the office

manager, laughed sheepishly to me as she described to me how she had learned what was fitting to this style and what was not. Soon after she started the role, she'd been asked to buy some new furnishings for the rooms and had gone out and bought red cushions and a red love heart carpet, because (though looking back on it she could not think why) she thought the women would like that.

“Well,” she said, “the therapist hooted with laughter, it was so— because obviously, you know, they were telling me that it would remind somebody who's been sex trafficked for instance of a hotel, or you know, I don't know what you call it, like a brothel?”

To me, it didn't seem as blindingly obvious as she now thought it was; I could see the logic, but I could also understand her original thinking that the red hearts might have made the women “feel loved”. In any case, the rug and cushions ended up in her house instead, and she purchased some more suitable alternatives for the office. The important thing was that they looked neutral, by which she meant categorically *not* red, whilst anything pastel would be okay.

It was partly these tacit assumptions from staff about what kind of safety the clinic space should offer— performed through such specific engagements with light, space and colour—that carried associations with the notion of “sanctuary.” But sanctuary was also an important theme in the way women described the centre. Yinka, a young woman I spoke to after her group therapy had finished, used the word to describe her first impression of the centre, and specifically to distinguish this from her prior experience in a hospital setting where she had been admitted with post-natal depression after the birth of her son. When I met her, she was in good spirits as she told me, with a huge smile on her face, that she had just come from signing the tenancy agreement on a council flat, which she will be able to stay in for at least a year. Seven months prior to that, she and her son had been housed in temporary accommodation when she found herself facing homelessness. It had been a horrible experience and she likened the block of flats to an old mental asylum:

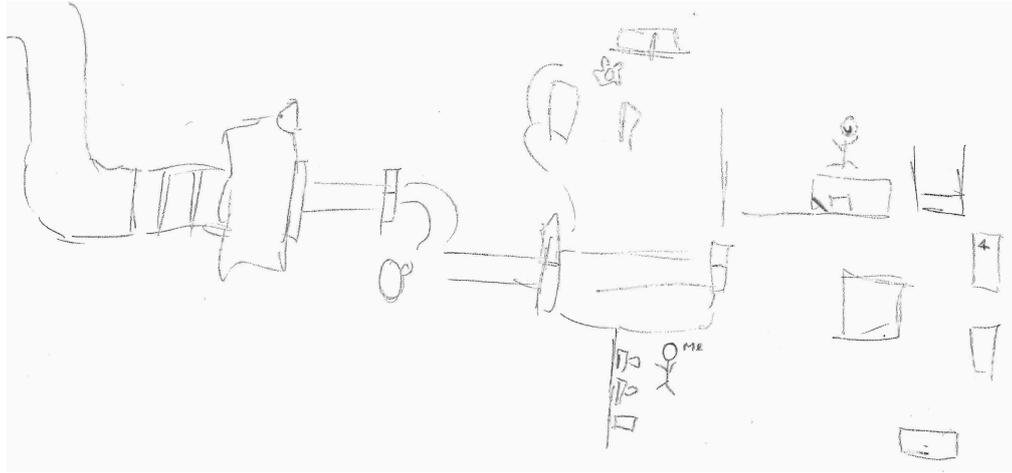
Yinka: it looks like, a bit like a mental home, a little bit, it had that vibe to it, like it was really dingy and it's just depressing. And it's, well, it's just, yeah, I don't know it's just like, almost like, it's the same sort of place they put people that leave prison, basically.

NB: And what was the mental home thing, what made you think of that?

Yinka: Because when you see films and you see when they kind of treat people with mental illness like animals, so that was like that place, it was like, it just wasn't suitable for a child at all, so, yeah, and it was just horrible, like there was damp as well, it was really cold, the heating never came on, so, yeah.

*Mapping: Yinka*

Yinka takes a pencil and confidently retraces her steps from the street, down the corridor, and to the women's centre area. She races through this route, sketching bits and bobs of furniture either side of the corridor—a water dispenser here, a table, a fan, this and that door. When she gets to the door that marks the area she was looking for on that first day, she slows down a little. She gestures towards the other side of the closed door of the therapy room we are sitting in, saying that she got through into that reception area: the big space in the middle, surrounded by all the doors to the therapy rooms. She draws what she saw there: a stick figure hovers above the shape of a reception desk, with nothing but a big smile on its perfectly circular head. She recalls the therapist who assessed her coming to meet her and bringing her to the room. It was room 4. She draws a small box and labels it with the number. Putting her pencil down and leaning back in a low comfy chair, she raises her eyes to the ceiling and remembers noticing the clean, white paint on the walls—*not* magnolia, she emphasises, with a small shudder. Oh, and then there were the paintings, she says; she liked their soft pastel colours, nothing too aggressive. What about the people? The fact it was all women? Yinka looks back down at the map, casting her mind back to the times she was describing. She had hardly noticed it at the time (she was so nervous, so concerned what people were thinking about her), but looking back, she thinks it was good that there weren't any men around. Back then, she has real thing against all the men in her life but it was her son that would make sure they stayed away—crying and crying and crying if a man came into the room.



**Figure 3: Yinka's map**

Perhaps even more than the human interactions she had on that first encounter with the service, it was the light and softness (in contrast to the dinginess that she associated with substandard statutory settings) that had brought Yinka to the term *sanctuary*. She evocatively sealed off the women's centre from psychiatric settings, prison, and sheltered housing that she drew from a combination of personal experiences and cultural references. Reflecting on what it was that made it feel safe, she also acknowledged the abjection she had felt against men when she was starting the therapy, and recalled that it had been meaningful to be in a women-only space. Others (particularly young women with precarious or unsafe living conditions) shared this sense of relief to be in a place of privacy or refuge, although this was also coupled with qualities of it being unfamiliar and sometimes uncomfortably intense. Both service users and staff valued the interiority of the clinic space and considered it to be (ideally) a site of protection from the outside. In this sense, the material aspects of the clinical space, so carefully put together and maintained, did what they were intended to do – they were neutral, clean, safe. The centre itself created a different kind of (non-clinical) space from other services: a break with the mainstream and “the outside.” But, as the previous chapter demonstrated, this “outside” is often not as easily sealed-off as the metaphors make it sound. And in this case in particular, the institutional “outside” was not just an abstract concept or memory from elsewhere. As I describe below, they shared a building with mainstream services, which had been encroaching on their clinical space for some time.

## **Encroachment**

In this section, I describe a different, more troublesome aspect of looking after the interiority and safety of the place. The series of events that saw the therapy centre become a professional clinic, expanding fast, then being forced to shrink down, was one that I heard narrated many times during my time there. It was during the build-up to the conference that I learned the rather romantic story of how the centre had started out. Stories were circulating about how the two founders had been great friends, fresh out of their training in psychotherapy and social work, and determined to start the first psychotherapy centre run exclusively by women, for women. They had started up the centre in the basement of one of their houses and promoted the service with handmade leaflets. I wasn't surprised that this story had been preserved and passed on with attention to these small details, within the grander narratives of women's liberation and radical movements in mental health. It spoke to values of self-sufficiency and taking ownership, of creating space for something different.

Several decades on, and they had long since moved out of the basement, into a complex of sturdy, nineteenth century red brick buildings that accommodate a cluster of well-established charities. A small, paperback book devoted to the history of the site of this charitable trust (handed to me at a community event nearby) tells me that charitable healthcare services have been delivered here since 1913. About six years before I started my fieldwork there, however, they'd stopped being able to afford the rent and sold off about two thirds of the floor space they had previously occupied. The space went to the NHS IAPT (Improving Access to Psychological Therapies) services that were being rapidly rolled out across the country at the time. The IAPT programme was in need of space to carry out their newly developed, evidence-based cognitive behavioural therapy practice. Despite the diversity of the women who worked or volunteered at the women's centre— both in term of cultural background and therapeutic approach— their feelings towards cognitive behavioural therapy was something that united them all. For them, the therapy practiced down the hallway felt shallow and bureaucratic compared to the psychodynamic methods they used. They felt that the women they saw needed much more in-depth work that took into account their biographies, their gender, and their different social and psychic vulnerabilities.

Even after downsizing, it was a constant struggle to keep the centre running financially, given that (as is normal for voluntary service providers) none of the core costs for rent, or other material resources, were covered by the project-based funding they received. To raise some extra money, they rented out rooms to various private practitioners, or the neighbouring NHS providers who were in constant need to more space. When I introduced myself to the receptionist for the IAPT service that sat at the desk outside of the new entrance to the women's centre, she nodded to the space around her: "you used to have all this space and we have gradually been taking it," she told me brightly, before adding that they also use the "beautiful" therapy rooms for crisis care when they had the chance to. Despite working within metres of each other (and shifting clients and services between their rooms), the two services had virtually no contact; the door in the central corridor sealed them off from each other completely. We couldn't see or hear the NHS counterparts, save for the occasional chatter and giggles of trainee wellbeing practitioners all piling into the meeting room next to the waiting area; comparing notes on assignments, managers and their clinical workload. I was told the NHS staff were "funny" with the them, and that I shouldn't take this shortcut to the toilets because it meant walking through their reception space.

To make things more complicated, the Women's Centre was jointly commissioned to do some of the service delivery in conjunction with IAPT, but the referral pathways between services weren't accompanied by much direct communication and were a source of tension. When cases were too complex for the six-session cognitive behavioural therapy course they offered, they would be referred down the hall through an electronic referral system—sometimes too thick and fast for the Women's Centre to manage. I was told they were being "bombarded" with referrals: their already shrinking clinic was under siege. There were instances where the inside/outside logic at the internal threshold of the centre felt strong for the women *using* the service too. The concern here was less about professional boundary work and more about wanting to feel separate from the cool, municipal healthcare setting on the outside of the door, and remain a part of something alterative and less clinical on the other. The internal threshold between these services was salient in the way most women visually mapped their entrance to the space. One woman, Kamila, whom I

spoke to several months after she started therapy, based her map on a stark “bad”/“good” divide between the IAPT service and the women’s centre, as she recalled essentially being forgotten about on the IAPT waiting list after finishing more intensive therapy in hospital, following a suicide attempt. She was angry that somehow the communication with mainstream services had suddenly broken down meaning she’d never been allocated to the service she was promised, but her distress also revolved around a relationship that had been plagued by domestic violence. Then, since accessing mental health services, some close friends from the community had been openly hostile to her; being outside of the formal mental health system was central what Kamila wanted from the Women’s Centre. So the spatial division between the services was not just a performance, but rather was constantly defined and reproduced by relations between clients, services, and their broader experiences of the health system. Whatever was sanctuary-like about this alternative space was deeply bound up with what staff, and some service users, felt was wrong with the mental health system at large, starting with the IAPT service down the hallway.

### **Dilution and Fragmentation**

The centre had not just been shrinking in the years leading up to my fieldwork. They had been reaching out to a changing “client group”: all the women on the front line (that is, delivering therapy and running the centre on a day to day basis) agreed that a vital change for the organisation had come with their turn to improving access for refugee and asylum seeking women. And so in many respects it was *also* expanding, albeit in a less visible way than the simple process of downsizing in space, described above. I now look to the changing the locus of work, which reached beyond the groups and settings associated with traditional psychotherapy—a change that, particularly in the beginning, had been met with scepticism. It brought different kinds of threat to sanctuary, which women described in terms of processes that I call “dilution” (of their practice into diverse spaces and places) and “fragmentation” (of the sanctuary, and whom it was for). In this way, the work of making the Women’s Centre more accessible paradoxically made it more and more difficult to maintain and hold together.

A potential alternative to this impasse, however, emerged out of the work of a woman I call Jehona: instead of working to protect the spatial and professional boundaries that gave shape to this particular notion of safe therapeutic space, she actively worked to shape-shift it and move it to ever more “hard to reach” places for the psychotherapist. Jehona was a community therapist and outreach worker, with whom I spent a lot of time, both in and out of the centre, working on (often overlapping) projects aimed at improving access for young mothers, and for refugee asylum seeking, and trafficked women. This was her specialism in part because of her own refugee status, which she gained many years ago but still strongly identified with. Despite having me tagging along with her, and another volunteer who would later take over her outreach role, she would often call herself a “one-man-band,” not reliant on anyone or anywhere to carry out her clinical work. In the pages that follow, I place Jehona in the role of antagonist or agitator to the traditional model of psychotherapy that provides safety and containment solely within the consulting room.

*Dilution: the politics of moving therapy “out there”*

One visible break with the established traditions of psychotherapy, which had taken place over the past ten years, was visible in changing demographics of the staff. The range of nationalities, cultures and languages spoken in the centre extended far beyond what it had been before (or indeed what you might expect to see in other services, largely due to the increasing levels of diversity both in the borough and within mental health professions in London). I was told this process of change happened in tandem with (and partly because of) the rapidly changing “client group” of the service. Over time, this client group began to represent a radical break from the typical (white, European, middle class) recipients of psychoanalytic psychotherapy. There were more and more women of colour and new migrants accessing the service, as well as those with low incomes that had already been coming to the women’s centre because of its provision of free services. It was impossible to determine a clear causation between the increased diversity of the service users and providers—most people gave a kind of “chicken or egg” answer when I asked—but the following account came from one woman who was able to share a distinct narrative of the events that unfolded over this period.

“In the end, some people had to leave because they couldn’t manage to work with the client group we had. You see, historically, this centre only worked with white middle class lesbian women with eating disorders.” Melek sits opposite me in her office, telling me this with a flash of impish glee in her eye, as she moves quickly through relaying what she knows of the history of the centre. I get the sense it is a story she has told before, and is happy to tell “on the record” (my audio recorder sits blinking between us). She has worked in the area for decades (weaving in and out of various voluntary organisations and her own private practice) and has been at the women’s centre for some years now. Crucially, she played a pivotal role in shifting the focus away from this “traditional” client group. She strongly identifies as a political refugee and foregrounds her identification as a cultural minority in her clinical work, fervently rejecting orthodox notions that a therapist must, or can, be entirely “neutral.” She tells me that when she arrived at the service in the newly created role of ‘community development therapist,’ she encouraged more diversity, focusing on migrant and refugee women in particular. She recounts how successful her work had been: how quickly they were “overwhelmed with refugees” and how much funding she brought in as a result. At first, Melek had no clinical responsibilities—the role was to go out to the community and help clients access the centre—but that changed as she began to push for more opportunities to carry out clinical work along with the job. She would give taster sessions, psychoeducation groups and, eventually, therapeutic work that would take place in various community settings. It hadn’t been easy; she recalls how many of the existing therapists had been very sceptical about taking the work out of the consulting room, telling her they didn’t believe she could be analytical in the community because she wasn’t neutral enough. Not only this, they would undermine the whole project of making therapy accessible to refugees: “oh refugees can’t use therapy, they don’t understand anything,” Melek says, mimicking the general attitude she remembers from this time. She reminds me that of course these more orthodox psychotherapists were all middle class white women themselves, and tells me proudly how, initially, people “on the outside” were surprised that she was able to work at the women’s centre as a *foreigner*. “Well anyway,” she says, “then things started to change.”

Melek’s account was part of a wider narrative shared by the “new generation” of diverse women who worked there. Without attributing quite such clear personal responsibility for the changes, most of the women would say the project to reach out to migrants and refugees is now a defining feature of what they do. The resistance to

it from the previous generation of therapists and trustees was referenced almost as a tale from a shameful chapter of their past; I never heard such cynicism or resistance first-hand.<sup>37</sup> And yet, the sense of protectionism— both of the psychoanalytical method and the clinic space itself— was, apparently, still felt by some, particularly with regards to the community-based work.

After some years, the organisation took on someone else to share the responsibility of the community work and expand it. This person was Jehona. One chilly February morning, I met her at a community centre where we were organising outreach event. As we trudged through a vast frosty playing field, outside of the quiet confines of the clinic, she recounted an experience that had confirmed her sense that the role was still not taken seriously as ‘real’ psychotherapy. She’d had an appraisal the day before and, faced with confusion from the board of trustees about what exactly it was she did, she told them again that she was a therapist. She was dismayed at the reaction they had given, of: “Oh I thought you were doing something ‘out there,’” Jehona waved her arm vaguely out towards an imaginary window to show me how dismissive the comment and gesture had felt. Apparently the “out there” aspect of her work remained synonymous with something ancillary or less serious than the clinical work done in the safety of the consulting room. Ironically, this narrative echoes the way the centre was described historically (in publications and oral histories about the centre), in that it had always been a space for doing psychotherapy in less orthodox ways, for people less represented in traditional client groups.

*Fragmentation: whose sanctuary?*

If Jehona was able to enact a form of sanctuary in far corners of the city, then what exactly did it look like, and how did it travel back to the original physical space of the sanctuary at the centre? What impact did this have on established ideas about what a therapeutic space looked like, where it was, and whom it was for? In a clinical presentation meeting, Jehona talked about her work in an Albanian community centre. Here, she had gone beyond delivering her usual information (or “taster”)

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<sup>37</sup> The politics surrounding the idea that the diversity of people and therapeutic practice was somehow *diluting* the established psychotherapeutic tradition at the centre was a complicated one. It is important to say that I never heard anyone say this first hand. Rather, it was the way that therapists who felt marginalised within the centre narrativised the changing priorities about *whom the centre was for*.

sessions and psycho-education groups, working individually with some of the women who were newer migrants in the community centre itself.

The room is full. Jehona sits in the circle waiting for people to settle; she is quiet, but somehow exudes an air of defiance just in the way she sits (very still, hands on lap, head held high). She presents an in-depth case study with one woman who had responded well to the therapy, describing how she had had to adapt to the non-clinical space—a storeroom from which she'd cleared rails of traditional dresses and other old pieces of furniture to make space for the two chairs they would place facing each other for their sessions. The novelty of the work strikes a chord with the women and, following Jehona's talk, they respond with positivity. Some even express their envy at her freedom to work like this.

Alannah, who had expressed her commitments to bringing classic psychoanalytic insights into all of the women's centre's work, sits thoughtfully for a while before sharing her response. What she took from hearing about this work that foregrounded the migration experience, was that really the distress and pathology *all comes down to trauma*. Moreover, she says, once you distilled it down to this, you could consider parallels with many other women's experiences, even a "rich woman from Belsize Park [an affluent neighbourhood] with her own kind of trauma." Some of the others nod in agreement, others look to Jehona for her response; a prickle of disagreement punctures the atmosphere. Jehona crosses her legs, takes a deep breath and nods, saying she understands the point but has to disagree. I worry about this comment, knowing from previous conversations how much she takes judgements on her work with migrants and refugees as a "direct hit" on her personally, as a refugee herself. There isn't much time to resolve the debate, but Jehona quickly defends her point that these women's experience of trafficking, or of escaping from conflict settings, *is different* to the problems of middle-class white women. The mood has changed quickly from a few minutes ago when we had been transported by Jehona's vivid descriptions of her work in the community, and we are faced once again by the many competing voices contained in this small room.

The work that was being put into making the service more accessible, to invite a bigger and more diverse group of women into the sanctuary they had created, was making it more and more difficult to maintain and hold together. Although the outreach work and community development therapy was firmly embedded into the

organisation's model, the splits and controversies it originally caused in the centre seemed to have remarkable endurance. Occasionally, in fact, it appeared that concerted efforts were made to keep these tensions alive. Those who worked specifically with refugees would tussle over who would narrate this particular struggle and critique the prejudice they felt (and sometimes still feel) in the resistance to it. Countless conversations revolved around how to protect this "radical edge" to their work. Others, in a parallel, would rail against the various corruptions of the original psychoanalytic method in all spheres of mental health care ("if only they would *read the texts!*" one particular therapist would exclaim, raising her eyes to the ceiling in exasperation at the absence of a Freudian basis in the new NICE-approved Dynamic Integrative Therapy model). Despite efforts to simplify the chronological development of "then and now," tensions continued to arise around what should be preserved, what should be left behind, and whether it was even possible to contain all the changes that were necessary and desirable in one unified professional and physical space.

These accounts of dilution and fragmentation reveal a paradox about the work it takes to make the service into a sanctuary for excluded women: enacting qualities of safety, interiority and inclusion seemed to make external threats and pressures all the more present. Striving to make this sanctuary accessible and inclusive made the contested and shifting boundaries of their work a constant source of tension. This shows a kind of flip-side to the tension I brought up in the conclusion of the last section: boundaries, of course, are necessary to protect and maintain a place of safety but they also make exclusion, contamination, and the breaching of boundaries all the more present, meaning that failure for the women providing this service was always imminent.

## **Fluidity**

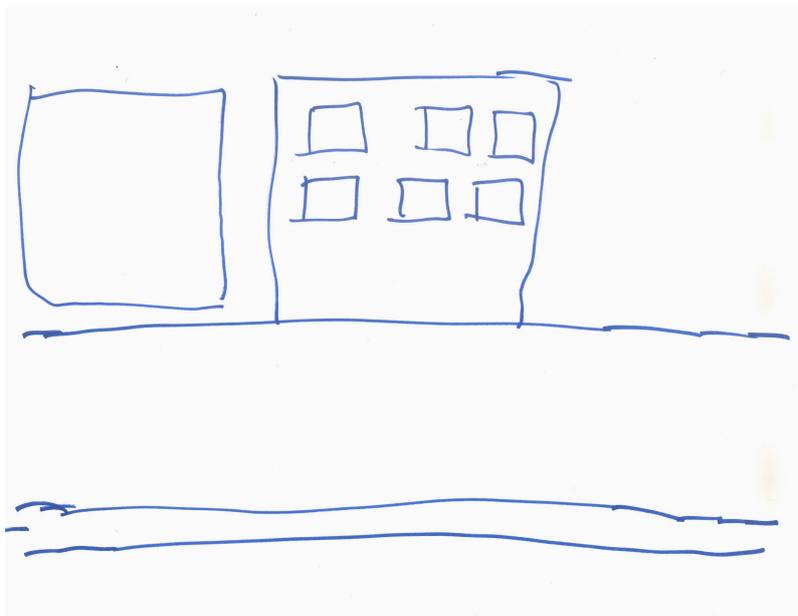
There is, however, a different way of approaching the work of inclusion, and of understanding what makes (and unmakes) sanctuary. Jehona's work was less about bringing diverse groups together in one space, and more about making the therapeutic work, and the safe spaces it created for women, more fluid and mobile.

Jehona would go to particular sites—community centres, libraries, advice services, and cultural centres—to target specific categories of women such as refugees, asylum-seekers, or disadvantaged young mothers. But the practice of visiting these various community groups introduced Jehona to all sorts of women; what she called “different *layers* of people.” She even set up WhatsApp groups of women after their group psychoeducation sessions ended, in order to maintain a digital space for support, and (she argued) enabling its own kind of therapeutic work between the women as peers. After several months of working alongside her and occasionally shadowing her outreach work, I interviewed Jehona. We met in café a few miles north of the women’s centre, close to one the community groups that she would be providing “taster sessions” for therapy to later on. I knew she relished being out of the centre, particularly when she was on her regular stomping ground, where she had a deep network of community groups, activists and service providers that she kept in regular contact with. Occasionally, though, her work would take her to unfamiliar places that heightened her sense of being a “foreigner” herself, and made her nervous about her own safety. This was what she communicated visually through her mapping; the only one that depicted a location outside and removed from any of the psychotherapy centres.

### *Mapping: Jehona*

Jehona fills the middle of the page with a “huge long road,” on which she’d “landed” after a lengthy bus ride to the other side of London, across the river, to an area she had never been to before. It’s one of the many, many places her job has taken her, she tells me; she tries to put herself everywhere. She had been asked to come and talk to a community group representing women with disabilities, at an event on the accessibility of health and wellbeing services. She says she’s using a nice, navy blue coloured felt-tip, because at the time it had been so depressing that she wants to make it look a bit nicer. The road is empty: no people, no houses, until she approached an estate. She draws the outline of a block of flats with rows of empty windows and remembers passing this huge estate that had been really dark. She tells me that she knew she was in a part of Peckham but jokes that it wasn’t anything like the TV show “Only Fools and Horses...” Another line takes us from the right to the far left of the page: another bus journey. This second bus went on and on until she got to the stop she’d been directed to in the email she’d received from the

community group. Describing yet more unfamiliar streets, she tells me how anxious she can get in unknown places. A single arched line suggests a strange eighteenth century gateway that she remembers having to pass through to get to her destination— “oh my God it was so weird, I didn’t know where I was going!” The memory sets off a peel of laughter, perhaps at herself, or perhaps at the absurdity of where her work was taking her: the mish-mash of English clichés, and her feelings of fear at being a stranger in a strange place.



**Figure 4: A fragment of Jehona's map**

The mapping reminds me of another story Jehona told me about danger and laughter, about a memorable bus ride, and about the mutability of (imagined) safe places. She was telling me about the first time she went to Albania, after a news report came out about human traffickers there. It was several years after she had left Kosovo, where she was from, to come to England during the war in the 1990s. Growing up, she told me, she and her siblings had imagined Albania to be “some kind of paradise,” beyond the border that had always been closed off to them. She described, with some irony, a pastiche of green fields and prosperity that they had held in mind all those years. After the war, she and her brother had to go to Albania to identify a family member who had escaped there, only to be tortured and killed because he was suspected of being a spy. They had flown to Albania, taking a bus that went overland all the way to Kosovo, where they would visit home for the first time (at least for Jehona) since they’d left. It was the bus ride that stuck in her mind.

As they drove, she looked out of the window to find a very different place to the paradise she had imagined. They made a stop at a roadside café, which looked so bleak they didn't want to leave the bus, but it turned out to be a stop for everyone's passports to be checked. When they got out, Jehona saw a group of men holding Kalashnikovs—jumping out of her skin, she was about to run when her brother told her that these were the police. That these macho men, barely in any recognisable uniform, were the police here made Jehona burst out laughing, which she couldn't stop even as the police talked directly to them, hearing their Kosovar accents. "It was the fear", she said. "Trauma is like that sometimes, its ridiculous, it comes out in odd ways." In the end, there was no real trouble and they boarded the bus, impatient to get out of there and across the border to Kosovo. When they did, she said, the irony was of course that it was Kosovo that looked like paradise to her.

Perhaps safe places take on a less fixed, immutable shape, when one's own experience of safety has been so fluid and changeable. Jehona's anecdote suggests that sanctuary (or paradise for that matter) is made and un-made by people, things, invisible borders and imagined places "over there" or "back then." That places of safety (one's own home, an imagined elsewhere) can switch unexpectedly disrupts the notion that sanctuary is static or fixed. The irony that the place she thought would be idyllic turned out to be somewhere dangerous and bleak, and vice versa, takes on a fable-like quality if you take the point of the story to be a moral about 'valuing home' or wishing to be elsewhere. But, knowing Jehona well by this point, I didn't take it to be driven by a rigid moral code, but rather, by an acknowledgement of the absurd and the unexpected—echoed also in her affective response to danger, somewhere between fear, laughter and a certain kind of contempt for having to go through it. Crucially, it was not so much about what "home" was to her, as it was about *what it became* in relation to the unfamiliarity and lawlessness she had seen across the border. Jehona's intimate knowledge of what it is to find oneself disillusioned and fearful in the very place that one was supposed to escape to clearly shaped the way she related to refugee women. It added legitimacy to how and why she wanted to make psychotherapy available to refugees and other migrant communities. But it was *also* what made her the "one-man-band" she always spoke about, creating a certain level of detachment from the centre, and the containment and safety that it promised.

## **Conclusions: An ongoing paradox**

In this chapter, I have described the making and re-making of “sanctuary” through different processes and spatial practices in the context of one of my field sites. I describe this being enacted through deeply political processes, which are concerned with, on the one hand, inclusion and diversity, and on the other, safety and preservation. All of these qualities could be said to “define” sanctuary, but my analysis has been informed by the idea that objects are defined by processes (Stenner 2014). As such, I have presented ethnographic material that animates three different processes, all of which have threatened the centre as a place of sanctuary: encroachment, dilution and fragmentation. Taken together, these processes create a story of constant gathering and dispersal: an inevitability, perhaps, but one which I saw as creating ongoing tensions and a painful sense of imminent failure. I have identified this as a paradox in the enactment of sanctuary—at least in this particular case. Enacting qualities of safety, interiority and inclusion made the external threats and pressures of the outside (mainstream psychotherapy services, financial pressure, compromised professional practice, and even particular groups of clients themselves) all the more present. This harks back to the metaphor I invoked in the introduction to this chapter, that of a lifeboat always being defined by processes of disaster and rescue.

Throughout the chapter, I used the somewhat antagonistic figure of Jehona to explore some of these tensions. In the last section, however, I used her story to suggest an alternative to the other processes I make visible here. Concepts of fluidity and mutability (De Laet and Mol 2000; Law and Mol 1995) helped me to analyse different, potentially radical approaches at play in this setting, although they never quite provide a solution to the paradox previously described. I also introduce the possibility of a more relational understanding of place, which emerges as an important theme in the rest of this thesis. But, crucially, I want to leave this problem unresolved, to pay due attention to the paradoxes that ran through the creation of sanctuary in this context, as well as the challenging (near impossible) nature of the task. Finally, I want to point to the inherently *precarious* nature of these places and the practices of inclusion that define them, which will be my focus for the next chapter.

## Chapter 6: Placing Precarity

### *Migration*

As it stands now, early on in my fieldwork, the therapy centre I call Culture in Mind operates from a tiny, solid building, squashed in between an express supermarket and a Lebanese café, whose tables and chairs spill onto the pavement outside. It is so close to the bus, train and underground station that you can hear the tannoy announcements from behind the frosted glass that separates the inside of the centre from the street. Today, unusually, I stand amongst the fumes of the buses with Miles, the director of the organisation and two more of its staff members. It is a peculiarly hot September day and although the air is soupy and close, it is good to take a break from the windowless therapy centre. We have had the fire escape propped open at the back of the building but there's no through draught because the front door must only be opened to let clients in via the security buzzer (as the sign makes clear: "By appointment only, please use the bell to enter"). We will be catching the bus about a mile and a half west from where we are now, to the site that is soon to become the new home of the centre. We want to see how the building work is going and "get a feel for the journey": K, who is the clinical manager and Semret, a community therapist, will be responsible for much of the relocating of staff and volunteers, and, crucially, ensuring that service users who may be half-way through therapy courses when the move takes place do not get lost and put off coming to the new site. The number 477 rumbles up next to us and we traipse up the stairs. We sit in two pairs of seats at the front of the bus and I read out the time on my phone so we can time the journey; it's twenty-six minutes past two.

As the double-decker rattles along from one side of the borough to the other, the conversation turns to what the clients might make of the new centre. Miles, in particular, has high hopes for this, although everyone is apprehensive about how the clients and staff will cope with the move itself. They have known for some time now that they would not be able to stay in the current building for long; the rent is being hiked to almost double what it is now, and everyone agrees that—even if they had raised the money to keep up with the higher rent—it wouldn't have been worth it to stay. For one thing, the lack of windows doesn't just mean the centre gets stuffy on hot days; the therapists have been saying for years that the windowless rooms are unacceptable, given that it is not unusual for their clients to have been incarcerated,

interrogated, or even tortured at some point in their past. The two therapists talk about their excitement at seeing the light and space of the new site, and Miles reminds them once more that they will find a window in every therapy room there.

The bus climbs the slight incline of a hill and we imagine what the journey would be like for clients who may want to walk to the centre from the main bus station or neighbourhood we would be leaving (and where many of the clients live). Then K steers the conversation onto a particular concern that had been circulating amongst the staff earlier that morning: she is worried about the doors to each of the therapy rooms. Some time ago, Miles had passed on her message to the builders that on no account should the doors be completely solid with no way of seeing in and out. It is a safeguarding issue, she had explained to him. When you work with vulnerable people in closed-off spaces, a third party needs to be able to sensitively look in to what is happening, without disturbing the client's sense of safety or privacy. Everyone had understood this: so far, so good. But the solution that builders proposed over the phone just before we left today made her certain she needed to come and talk to them herself: "We can't have *spyholes!*" K reiterates to Miles, hand on the metal bar on the seat in front of her, looking fierce. "People will feel as though they are in an interrogation room—it will remind them of surveillance, it'll create an atmosphere of suspicion." Miles responds with a fervent combination of nodding and shaking his head, "Yes, no, no we won't let that happen. We'll talk to them today. K is reassured that the builders will be put off the easier option of inserting small peepholes in each door and commit to building in a window panel in each one instead. Nevertheless, she continues to remind him that many people in *their client group* have lived through political situations characterised by suspicion and paranoia. The space must be a therapeutic one; she cannot have it making them feel unsafe.

The bus stops in leafier, more residential environs than we have just come from and we disembark onto a quiet street, following Miles up the hill and into a small mews. He explains that you can also walk a different way up to the mews and we all note that both routes could easily be missed—we would need a sign. We walk into a car park surrounded by a small complex of non-residential 70s-style buildings with big semi-circular windows and lots of beige brick. We enter a lobby area and stairwell with thick black bannisters and curved door handles. There is lots of building equipment being stored in here now but we are told that, happily, the people from the offices upstairs are going to let us use this lobby area as a waiting room, even though the space is not officially on the lease. Opening a second set of doors, into

what will become the clinic space, we are hit by a wall of deliciously cool air-conditioning, and a strong smell of gloss paint. Before I shake the hand of the site manager, who will show us the newly partitioned therapy rooms and their famous windows, I check the time on my phone again: it is a quarter to three.

In both the doing and writing-up of this short journey, I had a strong sense that there were several transition stories operating at different scales, all collapsing in on this 20-minute period of movement. We were moving through the city ourselves, the bus taking us outside of the centre and our usual day-to-day work. But we were also simulating the journey that the clients might make to the new therapy centre, trying to get a sense of what it might be like doing this for the first time (an experience we knew would quickly become obscured by our own routines of coming to work—or fieldwork). Then there were the logistics (and the politics) of the organisational move, which was occupying our minds and most of the conversation; and finally, the spectre of transnational migration, of seeking refuge from anonymous interrogation rooms or institutional settings in faraway places, as well as those of authorities in the UK.

Unlike the centre I described in the previous chapter, which went through a particular transformation to reach out to minorities, through their work with migrant women, this psychotherapy service has always been aimed specifically towards ethnic and cultural minorities. Many of this “client group” had lived in the communities the centre serves for their whole lives (for some, their parents and grandparents too). But then there were the newer migrants and immigrants, many of whom were refugees or seeking asylum in the UK. This heterogeneity spoke to the lives and the work of my bus companions, all of whom had their own (very different) migration stories, and had spent much of their working lives listening to those of others. As I have described in chapter 2 of this thesis, vulnerable migrants have become a great mobiliser of resources (particularly in non-state sectors), and the notion of *precarity* has become a key part of the vernacular to describe conditions of uncertainty, instability and placeless-ness. Having difficult, limited or non-existent access to health and mental health services is now often associated with these precarious lives. And so, what with the organisation having to move (itself being threatened with placeless-ness), there seemed to be a strange, and unfair mirroring of *precarious lives*, in these *precarious places*. This was articulated in the conversation I had with K, which I describe in chapter 3,

about how when she first stepped into the centre, she felt the building was reflecting the lives of the people it served. It is also something that has been noted in the literature on voluntary provision of care in the UK: associating “marginalised services... for socially marginalised people” (Johnsen, Cloke, and May 2005, 334).

## **Chapter overview**

In this chapter, I seek to problematise the idea that precarious lives and precarious places are pre-existent entities that echo one another in voluntary sector mental health care. Instead I ask how practices of inclusion and access may, paradoxically, *enact* precarious places, and equally, how places might *participate* in the making of precarious lives. And so, even as resources are mobilised to create places specifically aimed towards creating access to care, there is a reproduction of uncertainty, instability and the transitory nature of events. Broadly speaking, the first part of the chapter deals with the process and practices of place-making (how are places made, for whom, and according to what values) and the second part focuses on how places enact a particular kind of “precarious belonging.” I will do this through drawing on events, practices and moments of (service user) access that unfolded after the physical dislocation of the centre. Ultimately, I argue that precarity is (re)produced, not only by being out-of-place but by being *in and a part of* certain places at the margins of mental health care. I raise questions on what this means for logics of including the excluded, and how needs become legitimate in voluntary settings.

## **Belonging, in-between**

Well, historically working with refugees, you know, a refugee comes from many places you know, it changes. I think our place is in-between—you know, the place in between—not really belonging to one or other but actually bringing together from one and other to make it as whole.

Here, one of the longest-standing members of staff at Culture in Mind, was explaining to me why she thought that the organisation was “like a home” for the therapists as well as the clients. For her, it was not a place for any particular group,

but rather for accommodating difference and non-belonging. And so it seemed that the conditions for belonging here were not what you might expect, centring less around singularity, familiarity and static-ness; and more on difference, mobility, and “between-ness.” In this section, I chart the background to this particular approach to inclusion, and its relevance to improving access to care, as well as some of the material practices that went into performing these values in the process of place-making after the move I started to describe in the vignette above.

Part of what underpinned these values of belonging and being “in-between” was the fact that the service users and service providers could not be clearly delineated according to defining features such as cultural background, migration history or immigration status. The therapists, staff and volunteers all identified as coming from different ethnic or cultural minorities, and many were first generation migrants or refugees.<sup>38</sup> Indeed, the reason that K had been so appalled by the idea of installing spyholes to the therapy room doors, was that she had first-hand experience of living through an oppressive and heavily policed society; one in which she eventually fled as a political refugee. And as the service provided specialised care to migrants and refugees, values of safety, belonging and being welcome were given primacy. Crucially, however, “belonging” has not historically been something associated with psychotherapy settings (or mental health care more broadly) especially for those who do not fit the traditional moneyed, white, middle class, and (in the UK) English-speaking archetype. Exclusion and unequal access to such services had always been a driver of the work in this centre. And so these were dynamics that I had been told about as historically important to the establishment of the centre and in the biographical contexts of therapists’ lives, but I was also interested in the ways these

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<sup>38</sup> What this meant in mainstream healthcare contexts came out through anecdotes I was told from therapists who had in the past, for example, been daunted by beginning their psychotherapy careers working in an exclusively white working class area with supervision from older white men and no one to talk to about “difference,” or another who had been appalled at the racism of fellow students in a clinical psychology training course (“oh you’re from Iran— that’s where everyone has sex with goats, isn’t it?”), or simply the experience of feeling pressure to work in the NHS to feel like “more of a citizen” instead of a refugee.

values played out in the spatial practices and arrangements of everyday life at the centre, and particularly during the unfolding of the move.

It is the first working day in the new centre: boxes of files and books are being emptied onto shelves, the smell of paint lingers in the air. Fabeha, the office manager, has been here all weekend; she has her head down, sorting through clinical notes, and K is project managing. I am quickly enlisted to join her upstairs where she has learned that there is a whole floor of office furniture, which no one seems to be using. Apparently the service can use it, at least for the time being, which is handy as the existing furniture suddenly seems smaller here, and there is a lot more space to fill. I join her upstairs and we size up some bookshelves and various sized chairs. As we carry the bookcase down, bit-by-bit, I ask her about what, in her experience, makes a place ‘therapeutic.’

“Well,” she starts, “if you were to follow strict Freudian approach, you’d have everything *very* neutral, so people can have their own fantasies, not get distracted, you know? So just the chair and a lamp. No pictures. But the clients we have, they have had *traumatic experiences*, and so we always make it look more colourful, you know, with pictures and bits and bobs.”

The bookshelves are going to be good for storing some of the trinkets and statues I remember blurrily from the last place (the kinds of things that quickly fade from memory once they are moved off the shelf they have been on forever), and of course the many books on psychology, sociology, psychotherapy, counselling and anthropology.

I realise when we come back into the clinic space that we have all been whispering to each other. Everyone is shocked about how the sound of our voices echoes through the space, and soon we figure out it is because there are no soft furnishings and we have nothing on the walls yet. The walls are indeed very white and very bare right now, and so after the team meeting that afternoon K asks which of us is “artistic.” She wants someone to hang the pictures and wall hangings that have come with us from the old place, to make it all look “a bit less clinical.” I volunteer, and start unpacking the boxes of framed paintings and prints. I prop up the collection of framed images against one of the glass partition walls, dusting them off and wondering where they all came from. They loosely represent different cultures from around the world, and the only instruction I have is that I must not put all the art from one place in a single room (we can’t have a room that looks like “The African Room,” for example, because people might feel pigeon-holed). Earnestly, I follow

her guidance, making sure I mix and match the images: the African milkmaids here, the Indian silkscreen there, the colourful abstract canvases in the meeting room...

Slowly (and true to their commitment to cultivating a sense of belonging), the staff worked to make the place as homely as they could with effectively no budget; everyone brought in pot plants, for example, and we built up the kitchen supplies as every week a different pair would cook for everyone (bowls, seasonings, and a healthy supply of leftovers quickly accumulated over time). In those early weeks, when everything was so new and our surroundings so present and visible, there was much talk about which images should go where, which parts of the clinic should be open or closed, and in this way, questions of inclusion and difference came to be discussed through these mundane material practices. Crucially, values of accessibility, inclusion and belonging were not givens; they had to be made and re-made, partly through the creation of this “place in between.”

## **Precarious places**

The irony of all of this is that all this place-making was going on in the context of great threat to the organisation and their “not belonging” in the rapidly gentrifying area they had previously occupied. I have been describing how the move itself, and the events that unfolded in the weeks thereafter, made visible certain values held by staff members about making people feel they belong, “against the odds.” But *as well as* being a genuine enactment of these values, the move also made visible the precarious status of the places from which this service and others like it were being provided. It was something I would go on to see play out in various ways across small, community based services in rapidly changing urban areas like this one; a feature of the transitory, unstable nature of voluntary sector providers, which increasingly must be movable and ‘adaptable’ to changes in what they can afford and are expected to do. In the current system of commissioning clinical services in the UK, charities only get funding for providing the care (in this case, short courses of psychotherapy) and not for what are called “core costs,” such as the rent and energy costs needed to maintain a physical building. These were the politics and processes that formed the backdrop to the move and all the hard work that was going into it.

They also put serious constraints on the extent to which values of accessibility, inclusion and belonging could be brought into being, particularly in moments when clients encountered the centre for the first time.

Eve was one of the clients who moved with the service as she was part-way through her six-session course of therapy when the move took place. She had decided not to take up the full twelve sessions her therapist offered her, partly because the new site was that bit further from her place of work, and she'd already had to leave an hour and a half early in order to make it to her sessions at the end of the day. It was in this place of work that we met for our second interview. Eve had self-referred to the service, she told me, to give therapy another go: she had tried somewhere once before but stopped going because (as she put it), it had opened up a lot of doors to places in herself that she had not been prepared to go to at the time. She sought help this time because of a certain kind of "burden" she had started to feel in her body; a heaviness, which brought with it several bodily symptoms that she recognised as her body trying to process a particular violent event from her past, which her mind had not been able to. She had liked the centre, and particularly her therapist, when she first accessed the service, but when I asked her to think about the new place, her reaction was visceral:

"As soon as I got there, the first thing I said to [my therapist] was, I don't like this. First of all, why is it so white? I was like, I don't understand. It's huge! The rooms are huge, everything echoes and I was like, I don't like it." Much of Eve's mapping did the work of retracing and retelling this sense of exposure.

### *Mapping: Eve*

24<sup>th</sup> January 2017

In an administrative office at the hospital where Eve works

With hasty, feathered pencil marks on the far left-hand side of the page, Eve draws the driveway she remembers having to walk up before she encountered the outside of the building. Moving from left to right, she draws a quick wiggle for the steps you go up and then the set of glass doors: breaking with her birds-eye view perspective, these are drawn as she would have seen them face-on, oblong and divided with a severe line down the middle. Although she wasn't in any way secretive about being

there, she tells me, she can't help but notice how exposed you are, even when you are supposedly inside. "Even a stranger walking by could see you in the waiting room". The waiting room itself is less of a bounded area than an empty space ("just this huge... BIT") with sketches of furniture dotted around, such as a small sofa and the table with all of the leaflets on it. The door to the clinical area is drawn as one might mark on a floor-plan, or a symbolise a switch on an electrical circuit: it can be open or closed. Eve remembers how the receptionist comes to get you once you've buzzed, but then shuts the door again so you have to wait in the waiting area. Once you do get in, Eve recalls, there is no front desk, just more open space. Her gestures become increasingly animated and large as she sweeps the pencil across the page in annoyance. She depicts the open plan-style work space and the therapy rooms opening up at the edges; at first there is a faint line dividing up the area where the staff work at the computers, and the entrances to the therapy rooms, but she hastily rubs it out with the eraser on the end of her pencil. She says she doesn't want a line there, to show that it doesn't feel like there is any separation between her and the rest of the centre, "a lot of people don't like open spaces when they're talking about something that's quite personal to them" she explains, "and when something's quite big and quite noisy and echoey you kind of feel like you're being overshadowed."

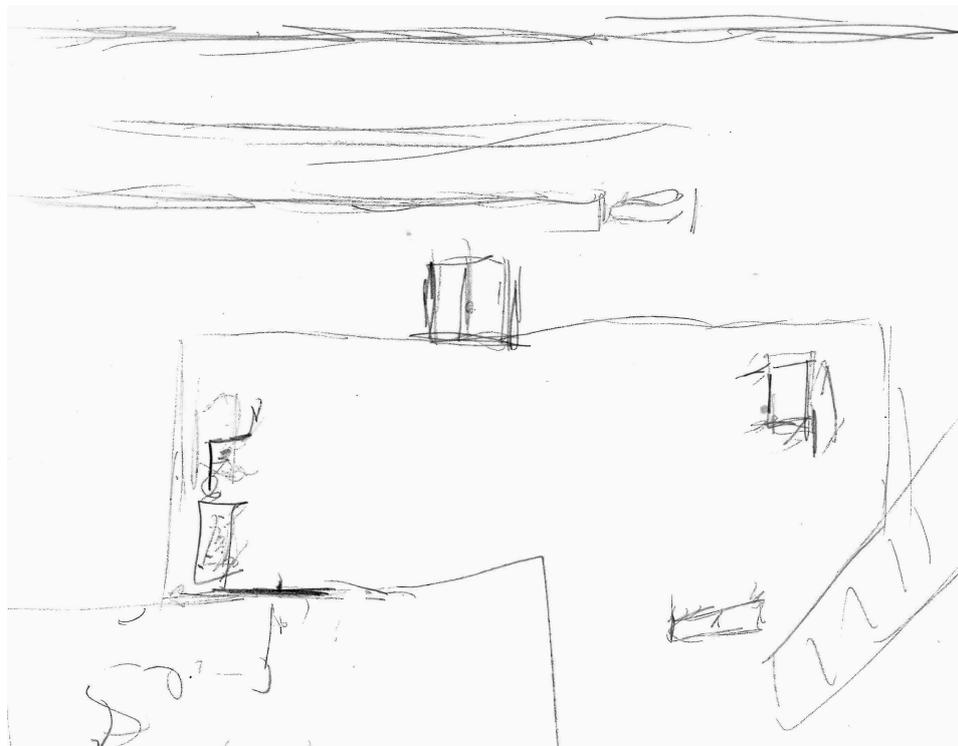


Figure 5: A fragment of Eve's map

So much of what Eve conveyed through the making of this image, and her oral narration, related to her embodied sense of the space and how sounds filled and travelled through the building and rooms. Her feeling of being dwarfed, exposed and overshadowed in the more public spaces of the new centre was strangely inverted later on, when she got into the therapy room, where she was more concerned about how loud and big she might be in the minimal room with thin walls. If she could hear the people outside, she thought they would certainly be able to hear her whole story, especially given her loud voice. Thinking about how voices so easily spill out into the rest of the centre, unbounded by the glass partitions, had made her yearn for the solidness of the old place.

Eve's account produced *a version* of the place that contained many traces of the wider constraints and conditions of the move: the underlying precarity of it all. It was by no means representative of a generalised "service user experience" (some were equally disconcerted by the new place, others actually liked the whiter, lighter space, and still others hardly commented on it) but it did perform a very different kind of place than the staff had been making, or hoping to make, through the practices I have been describing above. Eve's version of the place did not come as a surprise to me, and nor do I think it would have been a surprise to the therapists: there were many moments when the constraints to their work became painfully obvious. Recall the worries about the white walls, the lack of furniture and the way in which the voices travelled through the flimsy partition walls separating the therapy rooms from the communal space. But crucially, these problems and constraints were most visible immediately after the move and, for the staff, soon started to *disappear from view*. A white-noise machine was installed to mask the seeping voices, and although nobody found it to be completely effective, the worries and frustrated whispering between staff seemed to subside with time. Similarly, concerns that the open-plan work-space would make them feel too exposed was temporarily solved with the low bookcase borrowed from the offices upstairs. The place wasn't always precarious, or inherently precarious but *became that way* at moments of transition and newness, and the practices that unfolded in these moments.

## The waiting room

It is a quarter to three. As the time creeps closer to the hour, people will filter into the waiting room and—if they know how it works—ring the small electronic buzzer to tell the person on reception they are there. The door will open, they will be greeted and told to sit down, and then the door will close again. Then they have to wait for their therapist to fetch them and bring them to their room. Right now, there is just one man sitting in the room, opposite me. He is on the set of sky blue chairs, which are new additions to the space (last time I was here, there were only the two rows of upright metal-framed chairs with minimal padding on the seats and backs, clad in yellow plastic). He holds his phone loosely in his hand, half-heartedly scrolling and scrolling; he has the other arm's elbow resting on the arm of the chair, leaning back with one leg out straighter in front of him than the other. I am in here to observe how people are responding to the new TV screen that has been wheeled in here, set on a slide-show. The text, that changes once every minute or so, is a series of poems in different languages, with translations into English, or vice versa. The man has his back to the screen. I glance up at it and start reading one of them, and at some point he notices, giving a small start and abruptly craning round to look at the screen. Tentatively, I ask him what he thinks. He apologises unnecessarily and turns his whole body to face the screen, attending to the poem earnestly. It is in Arabic and the man, who tells me he is Iraqi, reads it swiftly alongside the English translation. In unfaltering English, he tells me it is a good translation and we chat a while about the next one—an Urdu poem of which he can only pick up the odd word. By now, another person has joined us: a man, a little older than the one I am talking to. He perches on one of the yellow chairs with his elbows on his knees, and glances up at the clock and down again. It's only a few minutes to the hour so he won't be here for long. At one minute past the hour, a third person pushes the door open. She is a big woman, and is breathing hard as she pulls open the glass door and takes a laboured step up onto the doormat. She presses the bell immediately but as the receptionist goes to fetch the woman's therapist, she stands back and watches the screen from across the room. There is just enough time for her to skim the poem—an English one with a Hindi translation—and catch her breath. Her therapist opens the door and greets her warmly; they disappear inside. One by one, they all filter out of the lobby and into the clinic.

I had been interested in this waiting room space from the first time we came to the site, when Miles had told me with relief that they had been able to secure what had been the lobby for their floor of the building and the one above as a waiting area, for no extra rent. It meant that they could have more clinical and office space and gave the clients somewhere informal to sit before they came in for their sessions. Because the organisation did not own the space, it remained undecorated, keeping its seventies-style brown carpet, and brown wooden doors. As the cliché of liminal spaces goes, it did indeed resemble something of a hotel lobby.<sup>39</sup>

The strange thing was, this place had surprisingly little to do with waiting. Clients had their appointments of fifty minutes, which never overran, meaning that (unlike in a hospital or doctor's surgery) their therapists were always waiting for them, if and when they turned up, on the hour. It wasn't until I had a particular encounter did I come to realise this: a woman who didn't filter into the clinic space when everyone else did. Sitting with her hands in her lap, in an embroidered black dress with a sequin pattern down the front, and a hijab, she wasn't holding a phone—as people normally seem to for distraction if they're not filling in forms—or any other reading material. We started talking and I learned her husband took her to the centre over an hour and a half before her session every week, because a gunshot wound to her leg (sustained some twenty-five years ago) made it too hard for her to walk or take public transport to the centre. She would also have to wait until he finished work for him to collect her. Amidst all that I gleaned about this woman's dramatic life story in Somalia, what made her exceptional was something much more mundane: that here, in this small waiting room in London, she was the only one who was really waiting. The gathering and filtering out of people every hour, just before the hour, was much more of a spatial gathering of people than a matter of temporal stuck-ness. All of *that* kind of waiting happened off site (and out of sight), when people were stuck on waiting lists until contracts were renewed and an appropriate therapist became available. The waiting *room* was a place to momentarily hold clients on the threshold of the main clinical space, more than it was where people would experience long

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<sup>39</sup> Places designed only for waiting have captured the attention of those interested in healthcare spaces (Buse and Twigg 2014, for example) and the cultural archetype of the hotel lobby has been drawn upon to highlight the strange liminality of these sites (Tallack 2002, cited in Buse and Twigg, 2014).

waiting times. The quietly patient Somali woman I met was the only one who was there throughout the gathering and dispersal on each hour.

So the waiting room *was* a threshold, a place to get “stuck” in, if only briefly. Crucially, though, it was a place where only service *users* got stuck; the staff (and myself) held a four-digit code in our memories, which we could punch into the keypad and then pass through the door into the clinic space whenever we pleased. And so being stuck at this threshold, in a microcosm of “waiting for access,” echoed the migration experience, but it did so *only for some people* (the clients) who were indeed accessing the service for psychotherapeutic care. Pushing this idea yet further, you could say that the service providers, who had to move location and set up shop elsewhere, were “migrant” only for one moment, whereas the service users, who have to move through and get stuck in this space every week, are *made “migrant”* every time anew. In the remainder of this chapter, I visit the waiting rooms of two women, whom I call Mariam and Dayo, both of whom produced visual maps that focused intensely on the material and spatial elements of this part of the centre in their moments of access, and whose experiences of being *made migrant* contrasted significantly.

## **Precarious belonging**

I met up with Mariam, a client I had met some weeks before, to talk to her more about when she first accessed the service. Because she lived a long way from the centre, I’d offered to travel to her for an interview, but she’d quickly refused, saying she did not want me to visit her home. Although she had moved out of the temporary accommodation she’d been in when I first met her, the house that the council offered her had a severe damp problem and leaked from the roof. Despite all of this, Mariam—originally from Eritrea—was glad she came to the UK, where she claimed asylum status two years ago. She had been trafficked across the Middle East by her ex-husband’s family after leaving Ethiopia where she grew up, believing she was going abroad for the opportunity to study. This time had been intensely violent, leaving her with complicated health problems. She was often unable to sleep and at times she was overwhelmed with sadness, though she didn’t want to take medication

for either of these things, which was one of the reasons she was referred to this centre for talking therapy. In the end, we met back in the centre, in one of the therapy rooms, under a tall plastic lamp, separated by a low table, from which I'd cleared the customary box of tissues and ticking Ikea clock.

*Mapping: Mariam ('imprisoned' on the threshold)*

18<sup>th</sup> January 2017

The meeting room at the centre

Mariam has finished drawing her map and we are talking about some of the things it has brought up. She is pointing to the part with her birds-eye view of the waiting room: four walls, a table, a chair standing on its own and a big cross in the middle, which shows that here, “you don't have *nothing*”. She has drawn the place swiftly, impatiently, with on-going commentary about her discomfort at its sparseness. The last part she drew was the inside door, the “secretive” one, leading into the reception and clinical part of the centre, with an oversized blob next to it: the buzzer, which acted like a security guard, stopping one from leaving the waiting room until called. It was this that made the waiting room feel like a prison for Mariam. She tells me that she can never relax whilst she is waiting to be called in. She had drawn this area in yellow, because “yellow means emergency.”

Having set out a particular place within the centre, Mariam now begins to bring herself into the scene in real time.

“Here, it is...” She looks sideways suspiciously as though at other clients in the waiting room. Again, she points to the map—to the wall where the rest of the seating is—setting the scene of two other people sitting there looking at her. Then she takes on the role of one of these women, looking back suspiciously whispering incoherently: “sschp sschp sschp!” and then, “she's... I think she's—” Mariam does the face of the suspicious woman, suddenly shocked, scared of something, and then bursts into laughter at the thought of this before going back into role. Now, the suspicious woman is looking across the waiting room at Mariam again murmuring: “is she working here? No? Then why is she coming here? What's her problem?” There is a comical back-and-forth of Mariam playing the two women trying to suss each other out by looking at the other, then quickly turning their heads away. Then she does the suspicious woman saying louder, “Why are you looking at me? Are you going to beat me?!” and then, with a sharp intake of breath, Mariam is herself again,

telling me with a laugh that this goes on until suddenly the door opens and she is called in. Only then she can finally leave this strange, tense encounter.



Figure 6: A fragment of Mariam's map (the waiting room)

This one-woman role-play that sprung up out of the mapping showed vividly the interactions between Mariam, the other clients and material aspects of the waiting room itself. She had made the comparison between the waiting room and a prison to me before, but her mapping out of the experience of waiting here enlivened the otherwise fairly generic metaphor, showing how specific ‘things’ (and a lack of things) had participated in this experience and evoked such a powerful and enduring association. She didn’t blame the other women who had seen her and been suspicious of her invisible but potentially frightening, or even dangerous, psychological issues. In fact, she later tells me that they are “just like her, and [she is] just like them”. But it is not just that the women were performing these subjectivities *in* a shared social space, the place itself—the waiting room—was entangled in the experience. *It was the door with the buzzer* that trapped them in there together (there was no ‘real’ security guard in its place) and the big open space in front of them failed to provide distraction or a buffer from the suspicious looks shooting between the chairs backed up against the walls. The lack of social cues and activities to occupy oneself with (making it unclear even who is a client and who works here) are characteristic of liminal places, designed only to wait in. It was also of course down to the fact that the centre had only recently relocated (a transition in itself) and there simply was not very much to soften or fill this empty area between the clinical space and the outside. Indeed, Mariam’s sense of uncertainty and vulnerability was bound up with *this particular* liminal place, as she described an entirely different feeling when

she was buzzed into the main space and joined her therapist, with whom she felt extremely safe and at ease.

Multiple and sometimes contradictory forms and metaphors emerged through the mapping of places, objects and spatial practices within one centre. Where Mariam conjured the up the image of a prison, Dayo, another young woman who accessed the service, talked of the centre as being a kind of sanctuary. This of course echoes the notion that was valued, though problematized in several ways, by both service users and providers in the previous chapter. Dayo's problem, in *this setting*, was that she didn't feel like it was *her* sanctuary. When I first met her, whilst she was still coming to the centre for sessions, she had been angry and frustrated with her whole experience of accessing psychotherapy, for lots of reasons but particularly because of the excruciatingly long wait and multiple assessments she had had to go through (mainly with her local IAPT service) between presenting at her GP and even getting through the doors of this particular centre. After the months she spent waiting for support—a period she called “being in a black hole”—she had found it hard to feel like anyone was on her side, even once she had started her sessions.

When we met again for another interview some weeks later, she was still resentful of what she had been through, but the anger had dissipated. She took me to a café in a corporate hotel near her house, with a plug socket next to every table for laptops, and a station for adding extra cinnamon or soya milk to your coffee. Reflecting on how the centre had appeared to her, she talked of it being a kind of sanctuary for people from different backgrounds and cultures. But Dayo, originally from Nigeria but completely at home in the UK, had always had a strong sense of being in the *wrong* place here in this ‘intercultural’ therapy centre. Her migration story was one of regular international travel with her father's company when she was growing up between Africa, Europe and America, before settling in the UK for a career in investment banking, which she'd recently been signed off from with chronic illness and severe depression. Was this the life of a vulnerable migrant? How vulnerable even was she, really? These were questions that Dayo herself was constantly preoccupied with during her time at the centre.

*Mapping: Dayo (being in the wrong place)*

24th January, 2017

A Holiday Inn cafe close to Dayo's flat

Dayo draws out three sections in broad felt-tip strokes, before choosing the middle section to work in. This is her waiting room. The space rapidly fills with illustrations of objects and spatial features of the room, which she narrates as she goes. On top of the outline of the table appears a box of tissues, a jug and a cup. She says hollowly that this had been hilarious to her: "the classic waiting room, with the water and the tissues. 'Get crying'"...the objects seemed to have been saying to her. Apparently, these items had appeared cartoonish to her even in 'real life,' before she had transformed them into two-dimensional motifs on the page. She had produced an image of them as stereotypes as soon as she walked into the room, and, quick off the mark, mocked them rather than fall into role as another stereotype: the vulnerable patient. But the pressure was on, because they weren't just there to be looked at, or even used if needed. They were *interacting* with her, expecting (demanding?) something of her: to be vulnerable, to "get crying." She moves on quickly to drawing the posters that she had seen on the walls, placing them full frontally towards us in the middle of the page. One has squiggles on that could be writing but we can't read it because, she tells me, it's supposed to represent a language she doesn't understand. The multi-lingual signage, which the centre is careful to display in order to communicate with as many of their client group as possible, had made her think the centre must be for women who were in the UK but dealing with issues from their own culture, a different culture. For the first time of many, Dayo quotes the line that had been going round and round her head: "Why am I here??" The other poster has a big 'CALL 999' on it and a picture of a telephone, which she later colours in red to explain the sense of alarm it had given off. How vulnerable was she, really? She felt sure that her therapist would think: "what have you got to worry about? Get out of here!"



Figure 7: A fragment of Dayo's map (the waiting room)

Paradoxically, then, Dayo did feel she occupied a precarious position here; her not being vulnerable *enough* made her undeserving of care here—or so she felt. Whilst she believed the place was *supposed* to be a “sanctuary,” she felt like an outsider and an imposter. Not only did she feel like she didn’t really belong, or want to belong there, she almost felt she would be expected to leave. Her vulnerabilities were hidden under a layer of perceived un-neediness and un-deservedness compared to the imagined group the service was *really* for. No one had told her this, but it was what she had taken from her surroundings. The *things* in the room were making her aware of her feeling of being *in the wrong place*. This is not to say that the tissues and water were to blame for Dayo’s insecurities about belonging and deserving care, but in the moments of physically accessing of the service, these objects were enlivened by the dynamics at play between a particular person entering into a particular space. Although very different to Mariam’s story, I see parallels in the way that this waiting room space became an active medium in producing their experiences of accessing care. What characterised such experiences was not straightforward belonging or exclusion but a sense of *precarious belonging*, experienced *in place*.

## **Conclusions: Precarious places, precarious lives**

This chapter has exploited a moment of transition (the displacement of the service from one location to another) to explore themes of precarity and displacement operating at different scales. I charted an uncomfortable sense, amongst some of the providers, that the service itself reflected the problems of the people it was serving. However, my analysis has suggested that the relationship between places and precarious lives is much more than a metaphor, or an unfortunate coincidence. I showed how a sense of precarity *comes into being* through encounters with place: in particular during moments of access and moments of transition. Attention to the entanglements of small moves and big moves, and to the stories of client-service encounters at particular *moments of access* has added detail and texture to how places are made, and how they make up experiences.

My argument, then, has disrupted the idea that precarious lives and places are pre-existent entities. Place-making practices were all centred on values of accessibility, inclusion and belonging, but these were constrained by the material conditions and politics of being a third sector organisation, itself excluded in lots of ways (from orthodox psychotherapy; from the security of state-funded services; or from the neighbourhood whose rent prices were too high). For some people, and especially at particular moments of access and transition, this *made the centre a precarious place*. Secondly, material and spatial aspects of the centre played into the transitory, uncertain, vulnerable experiences of people who encountered it. I saw people become more and less aware of the “surfaces” (doors, spyholes, flimsy/ leaky walls) of places, depending on the level of newness, (in)stability or (un)certainty of moments or encounters.<sup>40</sup> This enacted what I described as *precarious belonging*. This analysis of place and precarity is one of co-production of the social and the material world, which I will carry through into the next part of this thesis.

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<sup>40</sup> This can be thought of in a similar way to how Ahmed (2004) has written about pain and awareness of the body. Bodies, she argues, cannot simply appear or disappear, but rather, we can be more or less aware of their surfaces, depending on the intensity of our bodily experiences.

## PART TWO: NEED

## Interlude: “We need to talk”

Following the previous three place-based chapters, this interlude seeks to help me push the boundaries of my analysis beyond discrete spatial locations. I look to a more dynamic and multiple understanding of the places and spaces in which I situate my next two chapters on mental health “need.” In making this shift, at the juncture between the two ethnographic parts of the thesis, I perform the idea that I introduced towards the end of Chapter 2: of moving from *place* to *milieu*. Without repeating all the theoretical motivations for such a move, I do want to come back to the central ideas I revitalise from previous work on the milieu and talk about how they will shape my ethnographic exploration of need. First, and perhaps most importantly, a vitalist notion of milieu is consistent with what I have spoken about in Part One (for example, the social practices of making and re-making of place) but it tackles the problem of individual need within this. This is important because the mental health needs of individual person are pivotal to the questions and concerns I go on to explore in the second part of the thesis. Secondly, I move from ideas about relations between inside and outside to a much more contingent and distributed way of thinking about centres and peripheries, which allows me to shift to different scales of the care system. Finally, I think about milieu not as geographical space but a relational space through which need emerges, both as it is lived and felt, and as it comes to be *known*.

True to the vitalist commitment to putting the living being at the centre of its own milieu, I also seek to briefly place myself in the psychotherapeutic space in this Interlude. In doing so, I give an account of a self-reflexive endeavour, which was, in one sense at least, something of a failure. Through my description of this failure to make my own need known in a private psychotherapeutic assessment, I hope to provide a starting point for thinking through how need comes into being, how it comes to be known, and what it does across different psychotherapeutic settings and moments in time. Inspired by questions that arose during this episode, I go on to chart recent historical developments that tell us something about the changing constructions of “need” in UK mental health care. Whilst I do not claim to provide a genealogy of need (in the way that we have one of the milieu), this is a nod towards

Canguilhem's fascination with historical of attempts (and failures) to know aspects life (Canguilhem 1952/2008). As such, this interlude should be read as an introduction to and justification for the questions that will drive the second half of this thesis (and in no way a comprehensive "historical context"). In sum, I hope to tell a personal, but historically situated story, which provides some backdrop to the questions I address in Part Two of this thesis.

### **Being assessed, *somewhere else***

Following an ethnographic commitment to incorporating myself in the experiences and analysis of my field sites, there came a point in my fieldwork where I became increasingly conflicted about how I might come to know at least something of the needs assessment process, which always took place behind closed doors. The decision to avoid the therapeutic spaces in my field sites in was in many ways made for me; it is well known that what goes on in the consulting room can only really be knowable to any outsider by "hearsay" (Freud, 1915/1966). More importantly, I had no interest in intruding on private sessions of assessments, or worse, therapy. Early on in the fieldwork, the therapists and I had decided that the therapy room (which I have described in a previous chapter as a central space in what you might call *sanctuary*) would remain off-limits to me. And yet, as my research questions took me closer to the spaces where need is articulated and negotiated, particularly within the access experiences of service users, I felt I was missing something. I wondered if there was a way to put myself in one of those forty-five degree angle chairs and get a sense of the process of being assessed for therapeutic eligibility. What would it feel like to have my own "need" put under scrutiny?

Spending time with the trainee therapists that flowed through the organisations on six-month or one-year placements, I was reminded that they too faced the impossibility of "knowing" the client experience in the centres in which they were both working and learning. The solution for them, at eye-watering extra cost on top of their study fees and voluntary placements, was to organise regular private therapy. This, I was told, was about gaining some experience of "being" the client; of feeling, if never fully knowing, what it is to be the vulnerable party in the power-laden relationship between client and professional. This could not, of course, take place in their own professional environment where the therapists were colleagues and

supervisors, or in my case, research collaborators and participants. And so I realised, that in order to take seriously the method of “being there” to produce “truth” out of the fieldwork encounter<sup>41</sup>, I too should take myself *somewhere else*. Buoyed by my therapist friends, who mostly felt therapy was for everyone at least at some point in their lives, I called the number on the website one of them had recommended to me for low-cost private therapy.

The Centre for Freudian Analysis and Research offered psychotherapy at very low cost to students or people on a low income and would be provided by one of a pool of therapists in training, much like the volunteers I was working with. I would be allocated to one of them once I had attended an assessment meeting with a senior therapist. After the phone call, I was given an address to come to for the assessment. Weirdly, it was within half a mile of my university office in central London. A small mews, clad with sandstone and dripping with ivy and hanging baskets, took me off the roaring traffic of the Euston Road to a large blond wooden door. Then I came to a buzzer, accompanied by the typed acronym “CFAR,” answered by a middle-aged man with a heavy French accent. A strangely evasive greeting followed, typical of psychotherapists trained in the Freudian tradition of avoiding any relationship outside of the therapy room. Ushered in after a brief corroboration that he was expecting me, I was told to wait up some stairs in a living room-cum-library. It took me some moments to realise that this was a waiting room. Looking around at the densely packed bookshelves, Persian rugs and African masks mounted on the free wall space, I realised how far removed my field sites were from this traditional, almost anachronistic setup. And yet I was very attached to my idea that the experience would in some way echo the basic experience of the help-seeking client, ready to demonstrate eligibility for therapy. Running through how I might present my own psychological state and economic status, I was preparing to demonstrate appropriate level of need; to demonstrate that— although I was here in part because of my research— I had reason to be here and willingness to do the psychological work involved in the therapy on offer here.

The experience in the waiting room brought on an unpleasant sense of fraudulence or illegitimacy, particularly when I thought about the “real” needs of the men and women I was encountering in my fieldwork. (And here it is again, even in writing

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<sup>41</sup> This refers to Borneman and Hammoudi’s (2009, 10) edited text, *Being There*, which seeks to demonstrate what “anthropology can and does do through experience-based fieldwork.”

this: the sense of indulgence, of uncalled-for self-reflection from the worried well, or worse, the self-absorbed auto-ethnographer.) I resolved to “come clean” about my ulterior motive as a researcher (voyeur?) at some point in the assessment that was to follow and almost hoped that would put an end to the whole thing.

In the therapy room itself, sitting in the wicker and brown leather chair, facing the French man (who was now looking at me intently), I waited to hear his response to my confession about why I was “really” there; that my presence there was explained more by research interests than it was by a genuine neediness. The man barely responded, gesturing for me to go on, to tell him more about myself; what had moved me to do the work I do, my personal background etcetera, etcetera. Towards the end, there came the time to discuss money. Again, he was relatively uninterested in how *little* money I had, and wanted only to know that I would be able to maintain the payments for an open-ended period of time, which at the Foundation they tended to think was necessary in order to engage with the psychotherapeutic process. The presence of demonstrable or meet-able need—psychologically, economically or otherwise—was not driving the inclusion criteria here. Whatever the criteria by which I *was* being assessed, I seemed to have met them, as I was told to wait for an email with a therapist who would see me for a trial session.

Some weeks later, after receiving the email and making an appointment, I would find myself on the twenty-ninth floor of an enormous skyscraper, looking over a slick corporate Plaza in Canary Wharf. I would marvel at the pink marble in the lobby and the gorgeous grey woollen trouser suit of the therapist, and then baulk at another evasive greeting followed by an inscrutable set of exchanges. It would dawn on me that I could not be further from where I had started off – trying to get closer to my interlocutors “on the ground” in community-based care. A failure, then, in my attempt to extrapolate the client experience “there” to elsewhere; but generative for a different set of questions about both *place* and *need*: How was it that this relic of the past had, in one sense, ossified and contained in upstairs rooms clad with Persian rugs, yet in another, re-emerged in countless bastardised forms—in community health care settings, feminist basements, as well as in normal GP surgeries? How had this particularly orthodox iteration of the “talking cure” become so removed from the public provision of mental health care, in which treatment is so intimately linked to “need,” and services organised according to ideals of “supply and demand”?

## **Decoupling *talk from cure***

This account brings out my sense of alienation and distance from these anachronistic sites of psychotherapeutic care, compared to the publicly accessible psychotherapy services I was used to. This can be traced back to a growing distance between psychoanalysis and medicine: an increasing privatisation of a profession that did not engage with the kind of scientific scrutiny and critique which occupied most medical fields during the 1980s. Perhaps most visible was the sharp fallout<sup>42</sup> of psychoanalytic understandings of mental ill health during the so called “revolution” in Psychiatry with the third edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-III) in the United States in 1980 (Mayes and Horwitz 2005). Without becoming drawn into this vast transatlantic history of the rise and fall of psychoanalysis<sup>43</sup>, I do want to sketch this as the backdrop to a key shift in the way “need” came to be defined in mental health service provision; namely in relation to how it could be “met” and (importantly) how this could be evidenced. In brushing up against this grand narrative in the history of psychiatry, I hope to set the scene for the smaller, more localised projects that I go on to describe, which tell a different story to one of “psychiatric dominance” or psychological “therapy wars”<sup>44</sup> when it comes to the current definitions and constructions of mental health need.

The story of the DSM III is very much a national story in American psychiatry, which gets projected—both in academic discourse and through clinical practice—across global contexts. It is nevertheless, at least partially connected to the ways in which talking therapy has moved in and out of the UK mental health system in various guises. The UK does not actually use the DSM clinically (using instead the International Classification of Diseases or “ICD-11” as the most recent edition is called) though it is used for research purposes. The shift from the earlier, much slimmer volume of the DSM (based upon psychoanalytical clinical judgement) to a

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<sup>42</sup> The growing suspicion of the psychoanalytic tradition was articulated by Nobel Peace Prize winner, Sir Peter Medawar when he described the practice as “the most stupendous intellectual confidence trick of the 20th century” (Medawar, cited in Wilcocks 1994: 15).

<sup>43</sup> For this “rise and fall” story, see Hale (1995).

<sup>44</sup> The phrase “therapy wars” appeared in a 2016 Guardian Long Read article by Oliver Burkeman on the “revenge of Freud” in an age of cost-effective but increasingly unpopular Cognitive Behavioural Therapy, but had also been the title of Saltzman and Norcross’s (1990) book, charting existing “*Contention and convergence in differing clinical approaches*”.

far more extensive symptom-based system, certainly shifted thinking about both mental illness and its treatment in the UK. The mistrust in clinical judgement of individual pathology, in part fuelled by the anti-psychiatry movement of the 1960s, meant that the UK was also receptive to a more “neutral” and generalisable system, removed from individual aetiologies of distress. Diagnostic categories would then become an index of illness, which made clinical practice amenable to codifying and evaluating (Strand 2011: 296).

Though not universally favoured amongst mental health professions in the UK, this model of mental ill health— as definable and treatable like other diseases— was the one that would become “hardwired” into the logic of national clinical guidelines such as NICE (Turner et al. 2015). This generated a set of expectations for treatment for mental ill health to be evidenced-based, demonstrably removing or improving the symptoms that now defined mental health problems. This was a project that the academically— but not so scientifically— driven psychoanalysts had little interest in. The practice retreated instead into the private clinics and academic centres I described above and, of course, into the kinds of community projects that would become the services I describe in my ethnography. The resulting dispersal of psychotherapy out of this centralised project meant that it became profoundly decoupled from its previous role as a psychiatric “cure,” in mainstream mental health care.

### **Emerging languages of need**

This somewhat grand narrative of the incorporation of psychiatric nosology into evidence-based medicine provides only one version of the archetypal “mainstream,” which my field sites positioned themselves in opposition to. To contextualise the way psychological need was being formulated in the wider health system, we have to look sideways from both the highly medicalised sites of psychiatry and the lofty private spaces of the psychoanalysts. This requires a much more localised reading of events; in part, because there is only so far the transatlantic parallels go in terms of that particular universalist project in mental health. In the United States, psychoanalysis was historically much more embedded in medicine. Analysts were required to be

medically trained, unlike in the UK where the discipline was more autonomous, and which explains why psychotherapy became much more obviously eclipsed by psychiatry.

The UK saw more of a proliferation of surviving and new psychotherapeutic techniques in the 1980s and 90s, some of which, as I have mentioned, receded into private academic cliques. Others continued to be provided in the NHS, in an albeit “patchy” system of coverage (Haddock 1999). “Psychological therapies” were embedded in the NHS, described in terms of tending to individual psychological “needs,” which were assessed through a clinical “formulation” rather than a medical diagnosis. In the period following the 1980s, the organising principle of “needs” became increasingly central to mental health care provision, working in correspondence with other new but enduring concepts such as “costs,” “values” and “risks” (Turner et al. 2015)<sup>45</sup>. And so, in parallel to the hardening of categories in the psychiatric system, a different language of responsiveness and adaptation to individual needs was emerging. It was a language that the new eclectic range of psychotherapeutic approaches and health policies highlighting “treatment choice”<sup>46</sup> spoke well to. Although the UK has been well known for its bipartisan struggles in the anti-psychiatry movement, the “mainstream” of psychotherapeutic care in the NHS should be understood as much more diverse than these narratives suggest. In fact, would argue that this “mainstream” has become porous to and shaped by these very critiques.

## **The rise of IAPT**

The “mainstream,” in the context of my fieldwork, reflected the shifting landscape of dominant service models that I have been tracing; whilst psychiatric classification and

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<sup>45</sup> Turner and colleagues provide a detailed account of the changing relationship between mental health services, illness and need: “what is especially important for the historiography of mental health services, is the changing understanding of the definition of mental health or the scope of mental illness, and thus the ‘need’ for services... Understanding service development therefore depends on an historical understanding of the debate between formulation and diagnosis... far beyond the ideological struggle around classical anti-psychiatry.” (Turner et al. 2015)

<sup>46</sup> Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline (Department of Health 2001)

diagnosis would often serve as a kind of index of the mainstream mental health that these centres defined themselves in opposition to, the therapists rarely actually came into contact, or conflict, with *psychiatrists* in their everyday practice or through the referral mechanisms that linked them to other services. In the spirit of Freud's "narcissism of small differences," I could see that it was in fact another kind of talking therapy that aroused the most critique and concern from the clinicians I was working with. Talking therapy had existed for many years alongside the more dominant field of (now biomedically oriented) psychiatry, deemed useful for some but lacking an "evidence base." Then, talking therapy made a comeback in the form of cognitive behavioural therapy (CBT), which had its roots in behaviourist clinical psychology. Its roll out under the NHS was an intrinsically *empirical* project; by the early 2000s, the evidence base for CBT was growing exponentially and formed the basis for the national programme for Improving Access to Psychological Therapies (IAPT). The plan, led by "happiness economist" Lord Layard, was to solve what he saw as the dual problem of an unhappy population and a suffering economy: to "provide *equitable access* to [evidence based talking therapy] to all sections of the community on the basis of *clinical need*" (my emphasis).<sup>47</sup> Here, economic principles of *supply* and *demand* (not to mention profit and productivity) were explicitly used alongside the language of need.

Without delving too far into the debates and critique that followed the rollout of IAPT (I leave that to my interlocutors in the pages that follow), this new wave of standardised mental health service provision reignited some of the discontents from what I referred to above as the "therapy wars." Despite (or perhaps because of) the deluge of data and evidence that "proved" the efficacy of this treatment, questions about what people *really needed*, and how we were to define that need seemed to proliferate. "Clinical need," in the language of IAPT, refers to what are known as "common mental disorders", namely anxiety and depression, which are further defined by their low levels of severity. This level and type of need makes *anyone*— "regardless of ethnic group, age, socio-economic status, geographical location"<sup>50</sup>— eligible for this short term CBT. It was these universalist principles, shoe-horned into what had been a therapeutic practice grounded in relationships and individual need,

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<sup>47</sup> "Realising the benefits: IAPT at full roll-out" (Department of Health 2010)

that upset so many mental health professionals on the other “side” of the therapy wars. This was the opposition expressed by many of the therapists I worked with, who were committed to other forms of relational, psychodynamic or even traditional psychoanalytic psychotherapy, and who recognised “need” with explicit attention to difference, specificity and diversity of experience. But crucially, the logic of IAPT was less about ideologies of what precise therapy was being delivered or whom it was for, so long as it could be shown to “work.” It didn’t matter what the therapy looked like, if the data on recovery said that the clinical need was disappearing. *Need*, in other words, was there to be *met*.

### **“We need to talk”**

“We need to talk” is a slogan lifted directly from a manifesto led by the UK mental health charity MIND, the year before I started this project. When I came to read it, I was interested in the assortment of organisational logos on the front page, representing a coalition of “mental health charities, professional organisations, Royal Colleges and service providers who campaign for better access to psychological therapies for people with mental health problems” (MIND 2014, 2013, 2010). The “about the coalition” section, in its jaunty sans serif typeface, pleasingly transcended the stern, combative language of the “therapy wars” that I have been describing. The line itself seemed to work, not only because of its catchy word play (combining an advocacy message of de-stigmatisation and a serious call for services) but also from the simple definitiveness of the statement - enabled perhaps, by the plural pronoun “we” and its collectivising effect (*let’s talk, it’s good to talk, we all need to talk*). The job of these campaigners was to provide a call to action, in order to make these therapies universally available, and frame this as a public right. But in this interlude, I have taken a moment to dwell on the fact that even in the very recent history talking therapy has called into question each of the components of this seductively clear phrase; of what or who constitutes the “we”, the “need”, and the “talk” when it comes to delivering psychotherapeutic care.

My own personal concerns about “need” and “talk” hummed on, even after I had decided that the woman with the beautifully minimal trouser suit and equally

minimal Lacanian-style talking therapy at the top of the skyscraper wasn't for me. I found my way to a private therapist, in a plain converted townhouse in a terrace just around the corner from one of my field sites, who was also prepared to provide therapy at a student rate. I continued to go every week for the remaining months of my fieldwork. I had plenty to talk about in these sessions but the sensitivity to the indulgence of individual psychotherapy never left me. Interestingly, it was also something I would hear many times from the clients I encountered in the next stages of my fieldwork, regardless of how clearly they met the criteria for that service or how obviously "in need" they might appear to be. This was particularly (almost exclusively in fact) a feature of the conversations I had with the women who accessed the services. Relating their own need to others, and being concerned with whether they were needy enough or deserving enough was much more common than talk of whether their needs would be "met" with this certain kind of therapy.

Echoing these observations, I do not attempt to answer the questions wrestled with by practitioners, evaluators, and social scientists over the years, to join the debate about what people *really need* or to evaluate whether their needs are *being met*. Instead, I ask a rather different set of questions that can also be drawn from the same short slogan of "we need to talk". Who are the "we" that these therapies are meant to *serve*? Who are the "we" that gets to *talk about* or *define* "need"? And finally, how is "need" *articulated*, *operationalized* and *enacted* when it comes to negotiations of who gets what care in the field of mental health? It is these questions, and in particular the final question, that will shape the final two data chapters within this thesis, and that the ethnographic and conceptual work in these chapters will go at least some way in answering.

## Chapter 7: Making diagnoses absent: Proximity, risk and possibility in “doing things differently”

“The cultural issues we deal with here cannot be dealt with in the NHS clinical frame.” K is addressing the senior therapists and one of the administrators in the small, windowless meeting room at the back of the therapy centre. It is the first of the weekly Referral, Screening, Assessment, and Allocation team meetings I am present for, and everyone in the room is still reeling from a visit from the head of one of their local IAPT teams the previous week. He had come bearing unpopular news about the way their service must assess new clients in order to comply with the role that the commissioner wants the service to take in relation to its mainstream NHS counterparts. The team refer to their visitor as “him,” referring only to his organisational position to describe him, giving him a somewhat faceless, detached persona. As head of the “hub” of different mental health services that people would be referred to in this particular London Borough, he is responsible for making sure people are triaged appropriately across the different services. The therapists are recounting his demands—who should be “sent back” to the hub for reallocation, and according to what criteria—making it very clear that they are unhappy about what they have been asked to do. They ask rhetorically how they were supposed to make their own professional decisions under these instructions. “Well,” the administrator in the room pipes up, “he said that we need to ‘ask the right diagnostic questions so we can decide how best to help’” she says, quoting what she remembers from the previous meeting. K shakes her head and seizes on this, insisting that: “The diagnostic, NHS model is *not* how we work. We are a small organisation up against a big NHS; it is simply not true what he says—that ‘we are all the same in the eyes of the commissioner’—we are not the same, we do things differently here.”

*Doing things differently* was, perhaps paradoxically, a common theme across all three sites of my fieldwork: *differently* from the mainstream, and *differently* from each other, but through practices that I aim to draw parallels between. In this chapter, I focus on a common resistance towards using diagnostic systems to assess need and sort clients into categories. As such, my data speaks much less to the inherent (lack of) value of these diagnostic systems than it does to their function: what do they *do* in relation to the services I was working with? I treat diagnoses as an index of a more medically driven “mainstream.” This particular break from the mainstream spoke directly to my research questions about how mental health needs are enacted in voluntary

settings, and provided me with a starting point to thinking through what I would be able to surmise from my ethnographic material across three sites and at least two different sets of actors (clients and therapists). In all three sites, engaging with *difference* was a big part of their work to make therapy accessible to their respective client groups; both in terms of practicing different, non-orthodox kinds of therapy, and attending to diversity (of people, and of experience) when it came to whom psychotherapy was for. Central to this was the commitment *not* to ascribe to the sets of practices and epistemological frameworks of psychiatric diagnosis.

Crucially, it was not just that psychiatric diagnoses were entirely invisible or irrelevant in these voluntary sector clinics (as was the case with other biomedical practices or objects, such as pharmaceuticals). The vignette above, taken from my early field notes, illustrates that pressures to define and classify needs according to diagnostic categories was never far from their doors. And so the diagnostic system was part of an outside, but ever-present mainstream. Borrowing from the work of previous scholars, I take diagnostic systems to be an “absent presence” in the spaces I observed (Law and Mol 2001; Law and Singleton 2003). The absent presence is a deliberately paradoxical phrase, describing that which is manifest in its absence and performs the function of making *something else* present within a set of relations. Before exploring the various enactments of that “something else,” in the final data chapter, I will dwell here on the choreography involved in making diagnoses absent, paying particular attention to possibilities and risks involved when clients and therapists put this into practice. How do these different actors manage their proximity to the mainstream and its classification systems? What possibilities are opened up by making these classification systems “absent” from the therapeutic space? What risks and dangers come with being too close, or indeed too far, from these systems, which continue to hold so much power and currency in the wider mental health context?

## **Chapter overview**

My aim in this chapter is to demonstrate how the systems of assessing and sorting need were a function of key *relations* between the clients, the therapists, and (with a deliberate leap in scale) “the mainstream”. If we consider a relation to be a reference

back to something, or a comparison, that can be made *across different organisational scales* (Strathern 1995, 23), then observations of how people relate to mainstream systems become productive. In the vignette above, the relation is between the therapists at Culture in Mind (the voluntary provider) and the IAPT service (broadly representing “the mainstream”). Through their rejection of using diagnostically defined mental health needs, they performed an important sense of distance between their “small organisation” and the “big NHS.” After his visit, the faceless representative of the IAPT service provider was made distinctly absent, *and yet*, his visit would reverberate through the Tuesday clinical meetings for weeks to come. Their proximity to the mainstream had felt risky, the politics of which I will describe in the following section.

Through an exploration of this particular dynamic of making diagnoses absent from practices of assessing need, I look at three different relations: the relation between therapists and the mainstream (Part I, “Therapists making diagnoses absent”); the relation between clients and the mainstream (Part II, Clients making diagnoses absent) and finally, the client-therapist relation (Part III, Clients and therapists: different but close). I argue that the present – absent relations play a fundamental role in defining the relation between the two “presences” of the client and therapist: their therapeutic relationship, and their degree of closeness and commonality. In other words, the commonality between the client and therapist is contingent on their mutual difference or break with the mainstream, *a third node in this small network of relations*. But, as Strathern reminds us, “anthropologists do not pursue connections simply in order to be ingenious,” rather, they “route them in specific ways” (ibid., 11). I seek to route these connections through the men and women concerned with understanding their own and others’ mental health needs, towards some tentative answers to my questions about the risks and possibilities of going about this “differently.”

## **I. Therapists “making diagnoses absent”**

As I have started to explore above, to talk about an absence is not necessarily to talk about that which is completely invisible in a given space. Rather, it can be to talk about that which is actively made absent, and therefore always kept in view. I found this to be the case with the work it took for actors in voluntary spaces to make the frameworks and practices of the mainstream mental health system absent from their ways of working, whilst also being largely dependent on and (often) in close proximity to NHS providers such as IAPT. In a meeting similar to the one I opened this chapter with, but which took place in another centre, I was part of a long discussion about just this. Therapists were considering how they could continue to “work differently *in the room*, without labelling their clients,” whilst they felt pressure from “the system” to sort and classify clients in ways that (to them at least) felt pathologising. At stake was their ability to secure and maintain funding for delivering their therapy. Again *doing something different* was central to maintaining a “radical” and non-diagnostically oriented way of understanding and addressing the mental health needs of their clients. But what was painfully apparent throughout this meeting, and many others, was that doing something different was not just defined in relation to the mainstream, but was constantly *constrained* by it. This was an example of how the *work* of making the mainstream absent, paradoxically, makes this “system” particularly manifest and visible in these spaces. In the following section, I follow several different ways this played out, through continuing the story I began at the beginning of this chapter.

*“If they have anxiety, we have to send them back!” (The politics of need)*

The visit from the IAPT manager to the intercultural therapy centre had on-going ramifications over the months that followed. Despite her protests, K was not in a position to ignore the terms of their contract with the clinical commissioners that funded almost all their work for the residents of that borough. The commissioners took their guidelines from the IAPT service, and had made them the hub of all the commissioned services in the area, meaning that in instances like this, the centre was beholden to those who funded the service. The specific demand that therapists were particularly unhappy with was the injunction to send any referral whose “primary presentation” is anxiety back to the IAPT hub for a different kind of therapy. This

raised a myriad of issues, which challenged some of the core logics of the intercultural therapy centre's psychotherapeutic approach. Aside from concerns about people being unnecessarily "pinged back and forth between services," as one therapist put it, the demand posed a more fundamental challenge to the way the therapists assessed the needs of potential clients. It assumed that therapists could isolate one particular problem or disorder (anxiety), which took priority over other issues and would determine what kind of help a person would receive. I will turn briefly back to the clinical meeting I described above to share one more observation I made about how the ways in which the centre defines itself by "doing things differently" to mainstream mental health services. In this scene, their non-diagnostic approach was actively *performed* as well as narrated by the therapists in the room.

K leaves the room to fetch something that she wants to show us, and comes back holding a rolled up magazine, "Therapy Today." She sits back down in her place in the circle of chairs and flicks to the page she wants. It is an article about a recent study that was carried out looking at the wellbeing of NHS staff responsible for delivering IAPT services. Tracing the headline with her finger, she tells us that this caught her eye as she flicked through the magazine at lunch: that IAPT practitioners are themselves feeling the psychological impact of working to meet strict targets and high demand. And so, she tells us, if we are talking about anxiety, we must think about the fact that *he* must be very anxious working in the climate he has to work in. Rolling the magazine back up and tapping it on the palm of her other hand as she speaks, she explains that it is likely that in their meeting the week before, he was projecting all the stress of working in the IAPT service onto them. Her colleagues are quiet, but there are nods of agreement. There has been much talk recently of how politically charged the monitoring of talking therapies has been in mainstream services, and how everyone is having to prove that what they are doing works. B comes back to this a little later when he describes how the same IAPT manager had seemed to feel he had to defend the value of cognitive behavioural therapy by criticising the psychodynamic approach. He remembers him reprimanding the centre for providing psychodynamic therapy to "anxiety cases", because CBT advocates claim that it actually causes damage to people with anxiety. At this point, B shoots an apologetic look towards me, saying that this just goes to show how *political* this work has become.

Despite the therapists' obvious hostility towards how they were being asked to assess the client needs, the team were being fairly generous to the IAPT manager in the way they were contextualising his request, couching it in what they understood to be an intrinsically hostile professional environment. But their recounting and reading of the situation in this way did more than this. Not only were they naming the man's request itself as unreasonable—pathological, even—they were doing this in a way that performed their oppositional approach to naming a problem that could be called “anxiety”. K had contextualised the magazine article's commentary on high levels of stress, depression and anxiety in IAPT practitioners with her own understanding of the culture and politics of mainstream mental healthcare, to reframe what could have been described as an entirely within-person problem to be about the external reality of that individual. This echoed precisely what her organisation's therapeutic approach aimed to do when identifying people's needs; as well as attending to people's inner worlds, they would ask what political climate they have come from (and perhaps travelled away from), how other people in their community might be reacting to and dealing with this climate, and how this might be affecting their social relationships. Preserving this culturally informed approach to assessing and naming mental ill health returned us to safety, well away from the IAPT approach and its obsession with the category of anxiety. The magazine article had provided a window out into the much wider world of mainstream mental health care. We had zoomed out for a brief moment, before scaling back to the logics of the intercultural centre.

Framing different psychotherapeutic approaches as risky to practice with certain people, rather than simply ineffective, was a symptom of the so-called “therapy wars” rumbling on in background to these more micro-politics, in which psychodynamic approaches in particular had long been narrated by critics as dangerous and disreputable (see my section on the “therapy wars” in the Interlude preceding this chapter). However, from my seat in this particular circle of psychotherapists, and others in similar teams, I came look at the risks of assessing and meeting (or failing to meet) certain kinds of psychotherapeutic need in a rather different way. The therapists here were not afraid that clients with anxiety would “get worse”; in fact, they were candid about the likelihood of people feeling painful emotions associated with issues underlying *symptoms* such as anxiety, even at the end of their six or twelve sessions. As I will explore more fully in the next chapter, these therapists did not

require a client's needs to be entirely "meet-able" in order for them to be eligible therapy. However, they *were* concerned about their therapeutic work being discredited by the commissioning bodies they were dependent on to continue providing their service. Naming need in diagnostic terms made these organisations all the more at risk of being discredited, because they weren't able to demonstrate "recovery" from these psychological problems, as Cognitive Behavioural Therapy services seemed to be so good at.

The tendency to push away purely diagnostic assessments of need for the reason (amongst others) that "recovery" would become at once more expected and often less obtainable, was true for all the organisations I worked with, though I never saw quite such an explicit embargo, and on such a particular category of need, as the contract that excluded anxiety cases. "PTSD" was certainly a risky category to get too close to, because it sat so firmly within the medical framework for understanding trauma. Clinical managers were increasingly vigilant that their staff remained objective in their clinical notes, and they didn't have the tools or training to objectively back up these diagnoses<sup>48</sup>. Another diagnosis, which all three centres had to carefully choreograph their association with, was Borderline Personality Disorder (the most common of several personality disorders that clients might come with a diagnosis of); a category of need with a contentious history of being considered un-meet-able at least within the medical model (Castillo 2015). This category carries many other associations with risk, some of which I will touch on in the ethnographic material below. What all of these worries point to is the risk of the diagnostic model exposing them to the particular standards of the mainstream. At worst, they would be charged with a failure to meet needs that another service could, and in doing so precluding the client from receiving that other service. This wilful creation of spaces of *indeterminacy* when it came to assessing mental health need is a practice I describe more fully in the next chapter, pointing to the various ethical motivations for it. Here, I identify this practice as a means to avert the risks associated with being dependent on and operating *on the edge* of the mainstream mental health system.

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<sup>48</sup> This vigilance was necessary when therapists were asked for professional statements for appeals to the Home Office, or police enquiries about migration cases, because it was tempting to emphasise clients' trauma and need for care in the UK with a concrete diagnosis like PTSD.

*“Moving” and “removing” diagnostically defined need*

The injunction to “send back” people with anxiety from this borough (and soon after, another of their largest boroughs) was rarely a case of simply taking the highlighted word “anxiety” and sending that person back to the IAPT service. For one thing, this directly opposed the idea that they “take almost everyone” who comes to them, as W, the administrator, put it. Often, in this site and others, clinical meetings provided a space to think through how they would *differentially* describe a new client’s problem, so as to transform it into a need they could address. In doing so, they were able to make the diagnostic category of, say, anxiety absent from their service, without removing the *person* who carries that diagnostic category with them when they are referred. The focus of decision-making turned from risk to possibility. An example of one of these ways of *making anxiety absent*:

We are back in the meeting room for the Referral, Screening, Assessment, and Allocation team meeting. There are six of us in the room, including four therapists, an administrator and myself; there are a lot of complex cases to talk through today. By the time we get to this final case, my wrist is aching from scribbling down the minutes on each decision-making process for the team to use to communicate to clients, or—as was often the case—carry over to the next meeting when more information had been gathered about the cases, usually by telephoning people or the professionals that had referred them. This particular case had been carried over several times, partly because the psychiatrist who referred him, and the complex care team who are currently working with him are also unsure how to describe his presenting problem. K reminds us of the man’s background: a Turkish man who had been living in the UK for some years, with issues that his psychiatrist had thought could best be worked through with a Turkish therapist. When the psychiatrist initially referred him to the intercultural therapy centre, however, he informed them that this man had severe anxiety, as well as other complex needs. They hadn’t taken the case on for therapy that time because they felt that it might be better to send him to the complex care team; a decision that was further justified by the rule about sending back anxiety cases. However, K informs us today that, “His psychiatrist just called us back. Apparently they have tried *everything* in the complex care team and they want to re-refer him to us.”

She pulls the slippery cellophane file, thick with paperwork, from the bottom to the top on the pile that rests precariously on her crossed knee. With her hand resting on

the top, she tells us that from what she understands from his assessor, this man's problems are not only about the disorders he has been diagnosed with but also about negotiating his cultural identity and his sexuality. She announces that for this reason, she has decided they should take him in. She turns to the administrator who is with us, and says, "we need to *remove* the 'anxiety' as the primary presentation, and *move* this to a 'cultural issue.'" Then she turns to another of the senior therapists, "you should see him, as a man from the same culture who may be able to bring up taboos and break through them with him." An unusual sense of resolve settles over the room, even though they still do not know for sure if or how they will be able to work with the man. They decide they will call him directly and ask him in for a second assessment, a kind of consultation to find out from him how best they are able to help him.

Although it centred around a distinct and unusual case, this moment of (re)negotiating and resolving a decision like this spoke to other such moments, where a diagnostic label had to be "moved" or "removed" from the final assessment in order to make way for a justification, articulated in "intercultural" terms for taking a person on for therapy at this particular centre. Countless conversations came back to the idea that even if something like "anxiety" was "there" it was often interwoven with other things, or connected to larger underlying issues of trauma or cultural and geographical dislocation. Faced with a system that asked that they consider some people's problems to be defined by this diagnostic category, and therefore not eligible for the therapy they provide, the senior therapists made it their job to seek out and name the things that disrupt this notion of a medically defined "primary presentation". In this centre, it was working interculturally that shaped their view of the diagnostic system and its particular shortcomings. Through their practice, the diagnostic, *and* the alternative intercultural model of identifying mental health need came to be defined relationally. Making anxiety (or other diagnostic labels) absent from their practice was less about making it completely disappear from view than it was about keeping it in sight and shaping the intercultural approach in contrast and opposition to it. This brings us back to the idea of an *absent presence*.

The practice of doing things differently *this time* was about creating possibilities, rather than avoiding risk. The therapists could afford to bring the mainstream a little closer here, because of the possibilities for creating contrast and opposition, and

ultimately, the possibility of a different kind of care. This was something I observed at other moments and in different sites, too. I marvelled at the resourcefulness with which therapists could sometimes create different eligibility criteria, in parallel, and in contrast to diagnostic categories. Nour, a therapist I got to know well whilst helping her select people for a therapeutic group, took the category of “depression” and transformed it into a thematic idea that would allow her to include anyone she felt could benefit. She was interested in the taboos that got in the way of talking about painful experiences and so the theme she was working with was simply “saying the unsayable”. The diagnostic category of “depression” functioned to clear her a space for this different theme that expressly tried *not* to categorise people according to any one need, or set of needs. This was a particularly non-risky situation, given that the project was funded by a charity donor and was much less invested (than the IAPT commissioner, for example) in using diagnostic categories to organise the services they fund. All in all however, constant choreographing was taking place to manage how near or far, how in sight or out of sight, therapists could position themselves in relation to mainstream systems and practices.

## **II. Clients “making diagnoses absent”**

The previous section, I focused on the relation between therapists and the mainstream mental healthcare system, made visible by the on-going practice of rejecting the mainstream, through *making diagnoses absent* from their own assessment and allocation processes. I turn now to another relation, which was characterised by a process echoing those I have described above. By focusing on the relation between clients and the mainstream, I want to highlight how clients participated in therapists’ practice of making diagnosis manifestly absent from their encounters. It is important to note that rarely did I encounter explicit value judgements about whether diagnoses, or even diagnostic labels, were ‘good’ or ‘bad’ in the eyes of the clients (in contrast to many of the therapists, whose professional judgement would lead them to more explicitly reject this mode of understanding mental health need). However, clients did often actively push their diagnostic experiences in the mainstream away from their encounters in these voluntary spaces. This wasn’t simply a case of clients echoing what they observed in their therapists’ practice, and served a multitude of

different functions relating to how people wanted or expected their needs to be understood and articulated in certain places.

The story I draw upon to bring this to the fore is a series of several encounters I had with Samira, a young woman I first met early on in my fieldwork and whose therapist I knew very well. The layering of these different encounters over a period of time in this story built a more complicated picture of how different diagnostic labels were avoided or rejected by different actors, and to what end. The more multi-perspectival experience that this presented me with helps to push yet further the relational argument I have been making about how absences and presences are produced. I will continue to extend this argument through putting Samira's story into contact with her therapists' experience in the final section of this chapter.

*Samira: Different, disordered, or simply hard to place?*

The first time I met Samira, she was coming out of the women's toilets at Culture in Mind, entering into the staff workspace where I was chatting to some of the other therapists. She walked towards us, informing us that the tap needed fixing as it was stuck and wouldn't stop running. Wondering if we'd met before (she spoke boldly, as if we might have) I suddenly remembered that there was a new therapist that had been told I should meet. I held out my hand to introduce myself and asked the young woman standing in front of me if she was the new therapist. As soon as I did this, I felt a haze of incomprehension engulf us all. In the moments it took for our hands to reach each other it became starkly clear that I had made a mistake, and even before she opened her mouth I realised she was, of course, a client. The rest of the exchange was a clumsy realigning of positions, involving Feven (her therapist) stepping in to introduce us, eventually suggesting that Samira took part in my study as an interviewee.

By the end of this odd encounter, we were all set to meet the following week, clearly positioned, finally, as client and researcher. Looking back, however, I came to see this dynamic as less anomalous than I thought at that moment, and spoke profoundly to the many ways in which Samira was *hard to place*. I want to explore a little more closely how she had negotiated, and struggled with, her experiences of professionals trying to place her diagnostically; how she had put the ambiguousness of her mental

health problems to work, in order to evade one particular diagnosis she had received in her long history of clinical encounters. Again, diagnostic practice was at once being made absent, but remaining manifestly present.

Samira and I meet in the centre after her session, as planned. She is upset from what she has been speaking about with her therapist, but sits down telling me firmly she wants to stay and talk. I am moved by how at once vulnerable and tenacious she is. We decide to have just a short meeting and to arrange another time to talk properly, which Samira likes the idea of. She has moved around a lot recently but has just moved into somewhere she thinks she will be able to stay. Before she leaves, She invites me over to her house— she could do with the company, she says, and can make us coffee there.

For now I keep the questions brief, focusing on how she had been referred to the service, where she had heard about it, and so on. Samira tells me about how keen she had been to come to therapy and how it had really been her choice, even though her doctor had referred her: “I knew I needed it—somewhere I could release some of this...” she makes a gesture with her hands pushing away from her chest to show me how much she had been carrying with her. In the past, she had spent a lot of time being observed and assessed by clinical teams; not in Lebanon, her place of birth, but in Sweden where she had done most of her growing up, and in the UK. It was in the UK that one doctor had given her a diagnosis of borderline personality disorder. But, she says, it turns out she only got this diagnosis because of the traumatic experiences she had had when she was younger, and *not* because she *actually* had the disorder.

It takes some weeks for us to reconnect after this, as Samira has been doing lots of travelling, and when I see her again at the centre she tells me she is having a crazy time. Eventually she texts me out of the blue one day- can I come over now?? I arrive at Samira’s place and she is on the phone. She continues to talk to someone on a customer service line for twenty minutes or so whilst I sit myself down on one of her squashy sofas; I’m shocked to hear her thank the person at the end of the line for spending over an hour and a half talking to her. She doesn’t stop moving for the entire time I am there, asking me to pass her a huge armful of clean laundry for her to fold, between cigarettes, sips of tea and checking her phone, all the while talking to me, with impressive multitasking skills. Watching her, I think about her slightly

unnerving tendency to come across entirely differently each time I see her, but it soon becomes clear that whatever I find out about this dynamic and somewhat shape-shifting young woman will be inherently partial. One of the last things she says before I turn on the audio recorder is that she won't tell me the whole story in case I use it against her. But even this seemingly distrustful message doesn't match her warmth and generous telling of her experiences leading up to her accessing the therapy centre she is at now.

She talks candidly about the various diagnoses she has had imposed on her, sometimes rejected by her, and often simply forgotten ("I don't keep them to be honest"). Eventually she had received a diagnosis of Attention Deficit Hyperactivity Disorder, after being assessed yet again in a specialised psychiatric clinic based in a hospital "so big, so it kind of loses you". She accepts this diagnosis now, even though she was hoping not to get a diagnosis at all. Resignedly she tells me that in the clinic, it had been established that she is "fully different." In a rare moment of stillness, she looks at me steadily and asks: how could she be the only one who is right, whilst everyone else is wrong? Yet she still finds it difficult to take these doctors entirely seriously, recounting again how her diagnosis had initially been taken for a for a personality disorder. She thinks it was because of the way she had acted in the clinics when she became bored and frustrated with all the assessments. She would say, turning the doctors' unanswerable questions around on them: "okay, so why are your socks green?..." She shoots me a sardonic look, "They most likely thought I was stupid— like, mental— like proper, proper mental."

Whether it was the diagnosable *disorder* or a more difficult-to-pin-down non-coherence or *non-order* that explained why Samira was seen so persistently to be "fully different," there was something that had been waiting to be re-named, or at least understood in a new way, once she moved out of the psychiatric sphere and into the psychotherapy centre where we came into contact. She was well aware of what this diagnostic label would, or could, do when it came to accessing care; she leaned in to one psychiatric explanation of her distress in order to secure her place in the centre, but again, this was risky. Samira had taken the name of one disorder in lieu of another, framing herself as "different", but perhaps not so "mental" that she would be seen as *too* unwell or difficult to work with.

Once she had accessed the service, Samira felt, for reasons I will explore more closely below, that she was understood in ways she had not been before in the various clinics she had been assessed in, taken aback by how comparatively soft her therapist's approach had been to finding out what her problems were. I could not help but feel relieved for Samira that she had managed to reject the label she had first been assigned; it was a hard one to shake, and even in the voluntary organisations that made it their business to reject the diagnostic model, a personality disorder diagnosis in a person's records would be taken seriously. Having a diagnosed personality disorder was not a hard and fast barrier to being eligible for therapy in these organisations, but the assumption was they did not have the capacity to provide therapy for this kind of severe and enduring condition. Despite the apparent disinterest with which she stopped keeping her various psychiatric diagnoses (I was struck by the image of her tossing them aside, like old paper bank statements), she kept a close eye on the personality disorder. She spoke a lot about what it was, and how it could be confused with other things: trauma, an attention disorder, or just being different. Of all the people I spoke to who had previously been in contact with psychologists and psychiatrists from other services, Samira was at once the most rebellious against their assessments of her, and the most preoccupied with the marks they left on her. Others, for whom diagnoses were less risky, (could afford to) put much less work into distancing themselves from other services. They would tell me simply "I have depression," or "I have a sickness," before decentring this from their account, talking about different psychosocial issues that they had focussed on with their therapist. In line with what I observed amongst therapists, the work it took to avoid the risks associated with a particular category of need had a paradoxical effect: it made the diagnostic label manifest, and persistently present.

### **III. Clients and therapists: Different but close**

In the previous two sections, I have highlighted the ways in which therapists and clients make diagnostic practice and labels absent from the space in which these actors access and provide therapy. Looking at these processes from within the voluntary settings, we can refine this broad notion of *doing things differently* to talk about alternative enactments of mental health need, in contrast to mainstream psychiatric

or diagnostic terms. As such, it could be articulated more specifically as possibilities for “*doing need differently*”: an idea I will explore more fully in the next chapter. What the ethnographic data I have drawn upon so far has shown, then, is a series of relations between actors in voluntary settings, and an absent “mainstream.” Making the mainstream manifestly absent has taken the form of actively rejecting, subverting, or simply setting aside diagnostic practices and labels, depending on the possibilities and risks this entails for the actors involved. What I want to turn to now, is the relationship between the two “presences,” client and therapist, and think about how this gets shaped in the context of the relations I have described above.

### *Triangulating “difference”*

These processes of ‘making absent’ gave clients and therapists a common point of reference, which they may *both* make a break with, providing new affordances for the client therapist relationship. As such, far from being an entirely “absent Other”, “the mainstream” (embodied in the practices, technologies and labels of a diagnostic system) played an important part in shaping the relations that were more visibly present in non-mainstream assessments and therapeutic encounters. Moving beyond thinking separately about therapists and the mainstream, and clients and the mainstream, we can think about the mainstream as the third point in a *triangle*. The triangle has multiple resonances in psychoanalytic theory (Karpman 1968; Stern, Hard, and Rock 2015), though I draw on it simply to help me think through the relevance of a third component in a set of relations: at once directing the other components away from one another, and connecting them via that same point. I am interested in how people’s experiences with mainstream assessments of need had a bearing on their relationship with their therapist, and their sense of how their needs might be jointly understood, or even co-produced, *differently* in these settings.

As I have said before, there was nothing uniform about how clients engaged with or rejected the diagnoses they had inherited from other professionals—diagnoses are not in themselves ‘bad’. However, depending on which diagnosis we are talking about, and who has the power to name someone’s mental health need in that way, they can be risky. Similarly, alternative sources of therapy are not necessarily “better,” but they may open up new possibilities for understanding need, particularly when a space has been carved out where *difference* (rather than sameness, or universality) is explicitly

valued. In order to bring these ideas out of Euclidean space and back into the world I am attempting to animate with this data, I return to the story of Samira, her therapist, Feven, and my own brief entanglement in it.

### *A glitch in the client-therapist relation*

By the time I went to see Samira at her house, she had been seeing her therapist, Feven, for almost 12 weeks. This happened at a time when I was spending a lot of time with Feven at the centre. She had become more than someone I would encounter only during formal observations or whilst I was recruiting for interviews. Dragging a chair next to her desktop computer in the communal workspace, I would perch next to her, perhaps editing the English on her correspondence with clients' GPs or lawyers, stopping often to hear about the kaleidoscopic range of different work she did with what she called "the community." This community referred both to her own dense, informal Eritrean network, but also to clients she encountered professionally here at the centre, from various different cultural, ethnic and linguistic minorities.

Usually we would make a point of steering our conversations away her clients, who I had, or would be, speaking to in my research. But, standing in the kitchen chatting over tea, we were caught off guard when I received the message from Samira that she was back in the country and could meet. Feven spontaneously told me that this is the person that they had just been discussing in their clinical meeting. She had been seeking advice about how best to work with someone with a borderline personality disorder diagnosis. To my surprise, it turned out this diagnosis *had* been in Samira's notes, but Feven had missed it when she took her on as a client; now she felt worried about whether she could help Samira and declared that in this instance she should have paid more attention to the doctor's clinical notes than she normally did. Our conversation became stilted as I tried to square the multiple contradictions this brought up: not just that client and therapist accounts of the (mis)diagnosis did not match up, but also that Samira's story of re-framing of the problem in terms of trauma must not (as I had assumed) been the result of this team's assessment of her presenting problem. I worried about this divergence in the way Samira and Feven were relating to this diagnosis.

As I spent time with Samira that afternoon, however, I listened to her stories of her feeling chronically misunderstood by doctors, teachers and other professionals, and how grateful she was to have been able to build the relationship she had with Feven. More importantly, I realised the contradictions I had been hoping to decipher or sort out, about whether Samira “had” a personality disorder or not, were in fact simply sitting in the back of my mind, neither obscuring nor revealing what it was that had made Samira feel so understood by Feven. At one point, after Samira had told me about all the diagnoses she had received and rejected, I asked her directly whether she had spoken about these experiences with her therapist. She was unsure; they had, but then again, they hadn’t, because there was so much else to talk about. She told me was hard for her by then to know where her problems really started, as she had spent so long blocking them.

Crucially, she had had the chance to discuss all of this with her therapist in her mother tongue. Although her English was fluent, Samira had wanted to see a therapist who understood her background—they didn’t have to be Lebanese exactly but at least Arabic speaking, and a dialect she could actually understand. As it worked out, she had ended up with a therapist from another geographic, cultural and religious background; but it was someone who understood her mother tongue, and shared her experience of negotiating her cultural “difference” in relation to a majority culture. This could be found in the phrases that I had previously heard therapists use to describe how they would avoid trying to “match” clients and therapists culturally: *“not too close but close enough,”* and how they would say they were always *“working with sameness and difference”* in the therapy room. The way in which Feven and Samira related culturally echoed the way they jointly approached Samira’s presenting problem: in both cases, their relationship was shaped by the “third point” in a triangle, and in both cases, that point stood for a contingent majority or mainstream.

### **Conclusions: Different risks, shared possibilities(?)**

Returning to the way clients and therapists might *do things differently* in this space, or other non-mainstream mental health settings, there is more to learn from the triangle

relationship of Feven, Samira and the mainstream mental health services that I have been treating as an “absent presence”. It reveals that the risks associated with this diagnostic category were felt by both but were very different for the therapist than they were for the client. In a similar way to the risks of accepting “anxiety” cases into the service for a specific contract, accepting someone with a diagnosis of a personality disorder technically breached the contracts this service had agreed to work under. The potential for harm was evoked by the assumption that a voluntary service like this could not meet the more severe and enduring needs often connected to this diagnostic category and that were the responsibility of other professionals or services. In certain cases, like this one, the riskiness extended to the unpredictability associated with certain disorders<sup>49</sup>. But these proxemics of diagnoses and the mainstream were completely different for the people who carried these (potential) diagnoses. Clients were rarely aware of what and whom the service was for, beyond the information given to them by their referrers or on the website. In a healthcare system that was generally based around diagnoses being the gateway to some kinds of care, and exclusion from others, the riskiness was both harder to judge and carried more weight. Looked at in terms of risks, then, the politics of *making diagnosis absent* looks very different for clients and therapists. But what of the possibilities?

What was striking about the client-therapist relations across the body of ethnographic material was that there appeared to be a sense of understanding and attunement in these relationships despite differences in the interactions and relationships between clients and therapists. The case explored above shows that some professionals in voluntary settings did utilise diagnostic modes of classification and thinking when trying to situate the mental health issues of clients, however, these professionals did not make diagnoses themselves, and were committed to distancing themselves from the biomedical framework. This is important because it illustrates that it is not, of course, the case that *all* therapists working in voluntary settings *always* reject a diagnostic description of mental health needs. It is much more relevant and accurate to think about the way in which actors generally *position* themselves in relation to the mainstream and its expectations. It is this positioning that creates a space in which it

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<sup>49</sup> This riskiness was hard to ignore, once the problem had been named in this way; I too, noticed a reticence to “get too close” as I sat on the bus on the way to the outskirts of town on my way to Samira’s house, and an added edge on my responses to her eccentricities and contradictions.

is possible to understand, articulate, and enact needs differently. What becomes interesting about the phrase *doing things differently* more generally is that it can take on a double meaning in this space: not only are actors doing things differently to the mainstream, but they may all be doing things differently—even from one another. Just as client and therapist can be both different *together* and different *from one another*, they may also think differently about needs together, or think differently from one another. By making the mainstream, (its diagnostic practices and labels) *absent*, there is space for difference and non-agreement, but this always depends on that third point, constantly present and yet constantly made absent.

This was a chapter on relationality: how entities can be understood in relation to others, even as these relations span very different scales. In fact, the “big NHS” as K described it (“so big it kind of loses you,” according to Samira) next to these small community based centres was a key part of, and exemplified, their relationality. In this way, I have pushed my analysis of relationality further than an inside/outside contrast that arose in the first three data chapters, to one that begins to encompass multiple relations, of which I have analysed a very small network in this chapter. This nods to the radical relationality, which I described in my deployment of vitalist ideas; a relationality no longer tethered to a totalised centre in relation to an outside “surrounding,” but rather a whole network of relations spreading out from any living thing. This chapter was also about risks and possibilities (or potentialities) to do things differently, which were created by making mainstream systems absent from their practice. In the next chapter, I look at more active ways of “doing difference” and more specifically, build on a concept I have touched upon here, of “doing need differently.”

## Chapter 8: Doing Need Differently

### *Scene 1: Spilling out of the “IAPT box”*

The screening of new referrals takes place during snatched moments during the clinical manager’s impossibly busy day. The process is necessarily ad hoc, given that referrals have to be looked at before they enter the system, reducing the risk of them being unnecessarily added to the (consistently overloaded) waiting list. Today, I have asked to join one of these snatched moments. I lean in across the outspread files to watch the clinical manager stripe each relevant piece of information on the referral notes with a highlighter, commenting under her breath as she goes. The information she is highlighting will help justify why these cases have been earmarked to be “IAPT-Plus”: a strange category, which I haven’t heard before. The audible commentary and bits of highlighted text materialise as a fragmented list in my field notes:

An Iranian woman of 39: “Domestic Violence,” “Loss of husband after leaving eight months ago,” “Potentially a child bride when married.”

...

An asylum seeking Kurdish man: “recently migrated from Iran, to Iraq, to the UK” “PTSD” [she brackets this, saying she is not keen on the term, adding her own notes to the margin:] “Family shot in front of him,” “asylum claim rejected”

...

A British Caribbean man: “homeless” “in and out of psychiatric care,” and “a previous client at the Centre” [he called the service after his file was closed, saying “help me,” I am told]

As we take a last look over the final list of referrals, the highlighted text makes the case for these people’s need to access care painfully clear. And yet it also seems to massively exceed the remit of a community service, commissioned to provide talking therapy for low level “common mental disorders.” This, I find out, is what “IAPT-Plus” is for: a label that has recently been made available to services which are “similar” to mainstream talking therapy services, but which have been commissioned to enable the inclusion of people facing different, more severe problems. It has been introduced amidst difficult, on-going negotiations between local clinical

commissioners and practitioners in voluntary sector services about the parameters of “appropriate need.”

If the previous chapter was about the work that goes into making diagnostic categories absent, then this chapter can be understood as an analysis of the work that goes into making that *absence* into a *presence*. Where diagnostic categories of mental health need were seen to be something that were too medical, too individualised for the values that have long been established in these voluntary settings, I have described how both users and providers sought to do things differently. I came to refine this concept, with an eye on how it works in the assemblage of practices, places and concepts that make up “access,” landing on the practice of *doing need differently*. I focused on the relations that this enacted between different sets of actors; specifically, how the relation between client and therapist was shaped and enabled by the absence of the mainstream. What was important about this relationship (between client and therapist) was the space that this created for something *other* than a medicalised or mainstream psychotherapeutic encounter such as CBT. I framed diagnostic categories as an “absent presence” (Law and Mol 2001; Law and Singleton 2003): that which is manifest in its absence and performs the function of making *something else* present within a set of relations. But what is the “something else” that the absent mainstream brings into being *within* each site of alternative mental health care? How exactly might this afford different, non-diagnostic enactments of mental health need in each therapeutic space? And what tensions remain between the ways in which need comes to be felt, articulated, and made known across these spaces?

## **Chapter overview**

In this chapter, I look at the internal logics around need within each site, even as these actors wrestle with expectations and demands from the outside. I will “zoom in” on various scenes of negotiation, which all say something specific (but interconnected) about the concept I introduced at the end of the previous chapter, of *doing need differently*. This data will make visible the work, negotiation, and pitfalls involved in this practice, specifically for practitioners involved in the administrative work of inclusion or exclusion at each service. The scene I have just sketched above

hints at the on-going negotiation and compromise, which practitioners carried out in order to maintain a space within which they could provide therapy for problems that “spill out” of contractors’ and funders’ conceptualisations of mental health need. Throughout parts 1 and 2 of this chapter, I will return to this particular story to explore what exactly the “IAPT-plus” category was and what function it performed in this particular voluntary organisation. The unfolding of this story will help to move my analysis on from the more discursive practices around what *doing need differently* ‘should’ look like, to the hard work it takes to uphold these ideals in everyday practice.

In the second part, I extend my gaze to other scenes across my field sites, in which I trace the labour-intensive negotiation that took place once these ideals “hit the ground” in clinical practice. These scenes, in contrast to the discursive spaces of the first part, are characterised by messy, murky and perilous enactments of need through administrative work, clinical decision-making and the day-to-day struggle to maintain these organisations’ capacities (financial, therapeutic, social, spatial) to provide care. These frontiers of negotiation are where need is produced and where this need, in turn, produces eligibility for care. And so whilst these scenes show how need is uniquely negotiated and “done *differently*” (in different places, by different people, with different values) they *share* these themes of productivity and the on-going labour of inclusion. But what is strange about both of these spaces, is that they are purely professional spaces, devoid of the “*human-in-need*”, as I describe it in the last part of this chapter. The third part of the chapter therefore forms a discussion around this (non)-negotiability of need, exploring a final space that was largely invisible to me: that of the therapeutic encounter. In all the centres, there was a very “human” encounter of a clinical assessment, the length of a therapy session, that was central to clinical decisions about access. I present this human encounter as just *one* of the ways in which need emerged in a milieu, but one that was particularly valued by my interlocutors because of an ethical commitment to understanding need as located in place and time.

### *Tensions and entanglements between lived and known need*

To make sense of these spaces in which need is negotiated, enacted, and produced as eligibility criteria for care, I make use of the concept of the “milieu,” as I have described it in earlier chapters of the thesis. As a “fundamentally relative notion” (Canguilhem 1952/2008), the milieu works as a category to understand the relation between living things (such as *the human in need*) and their environments. The ethnographic material speaks to the way that need emerges differently at different sites, but that there is nothing pre-determined about this, because each person shapes their own milieu. This opens up possibilities to look at the ways in which need is produced *vis a vis* different environments within various scenes of negotiation: the way that, in practice, needs do not simply exist, waiting to be named, but rather they are produced in relation to specific environments. In this case, they are produced in relation to places of therapeutic care, which contain very particular value sets, as well as having their own capacities and boundaries.

The scenes in this chapter show the painful tensions and entanglements between lived and known need. This means my analyses go beyond the clinical encounter and attend to the administrative, professional (and yet often distinctly affective) spaces where need comes to be known and legitimised. In this way, these spaces are part of a milieu that has multiple constraints, constantly being negotiated by both therapists and clients. Here, need is not *only* felt or experienced moment-by-moment but also must be pinned down and made legible through clinical and administrative practices. I argue that whilst this is a productive space, it is one of ethical compromise and constraint. It is also indicative of the constant tensions between need that is understood as “different,” indeterminate, limitless and need that can be contained and fixed to eligibility criteria. In the pages that follow, I grapple with questions of how care providers struggle with these tensions.

## **I. What should “doing need differently” look like?**

I was interested in the ways that these voluntary organisations articulated their approach to need, and “meeting needs,” particularly when it came to differentiating themselves from mainstream NHS providers. In the previous chapter, I framed the

“the mainstream” in relation to other actors (the people and places that make up the voluntary sector, in this case), suggesting that it is not a fixed point, but rather constantly (re-)defined in correspondence with these other actors. In taking such a relational perspective, I do not, however, want to obscure from view the clearly oppositional sets of knowledge about mainstream/alternative approaches to mental health, which were described and reinforced by many of the people I came into contact with in my fieldwork. For example, the understanding that mainstream services such as IAPT have based their assessments of need on universalist principles, which may not be useful for more specific client groups, whilst community-based services can better understand the needs of women, ethnic and cultural minorities, or people suffering the loss of a loved one. As Anna Tsing (2015, 122) reminds us, even though most dichotomies are oversimplifications and suffer as soon as they “hit the ground,” they can be useful tools, because they urge us to look for difference. Such differences are worth teasing out, before diving into the ways in which they might get negotiated, merged and stretched in everyday practice. Let’s call this particular dichotomy *mainstream need* versus *doing need differently*, and look to an instance where this dichotomy was played out in discursive practice (Bacchi and Bonham 2014). The exchange below brings to light a rare moment when a representative of the (usually distinctly “absent”) mainstream came into one of these voluntary spaces.

### *The “IAPT friendly” Outsider*

The clinical meeting at Culture in Mind is different today; the usual cosy circle is interrupted by a PowerPoint presentation, projected onto the television screen that Miles installed in the new place but is rarely used. We are all sitting a little straighter than usual. There is an Outsider here, someone from the local IAPT team, come to tell us about how the “recovery system” works and how the centre can improve its recovery rates. The organisation needs to know this because, although they are not an IAPT service and work with their own specific client group, they have been commissioned by the NHS and are monitored using the same system as the mainstream services. The problem is that they are nowhere near hitting the national IAPT target of at least 50% recovery rates, which in theory they need to be reaching if they want their NHS funding to continue. As the therapists filter in and take their seats in the horseshoe formation, I learn that the Outsider is not a complete stranger, being an old colleague and friend of a senior therapist who recently left the centre. Both men are part of the Turkish community and would cross paths working with

Turkish speaking clients. One of the other therapists leans in to share this information with those of us who can hear, reassuring us that it means he should understand at least some of what it means to work with “the community”. There are high hopes that he will play the much-needed role of mediator between this small room and the huge spectre of IAPT, with its stark measures of mental illness and recovery, and its unreachable targets.

As the presentation rolls on, and the interjections come in thick and fast, I realise this debate on how to improve recovery rates has less to do with becoming better at *meeting* need (there seems to be broad agreement that they are doing a good job, and as well as an essential one), and more about discerning which needs they are (and are not) responsible for meeting. More specifically, a stark differences are being made visible between the Outsider and the Insiders on how need should be defined and contained. On the one hand, there is a commitment to staying true to the rigid IAPT criteria of severity and type, and on the other, the expansive psychosocial concerns of the intercultural therapy centre are being rearticulated and defended.

Early on in the meeting, it seems like the therapists might be persuaded to adapt their gatekeeping practices so that they will take only clients who fall into the “depression” category of common mental disorders, and levels 2 and 3 on the mental health clustering scale for severity.<sup>50</sup> The reward will be that their recovery rates will be better and their contract secure, but in order to get to this point, they will have to make sure that the clients they take on are—our visitor chooses his words carefully—“IAPT friendly.” As the back and forth goes on, and senior therapists describe insistently the consequences of ignoring the linguistic or cultural needs potential clients come to them with (“they will have nowhere else to go”), the advice from our visitor becomes more stark: “You really need to work hard at choosing people who fit into *the IAPT box.*”

His choice of metaphor is unfortunate, given this particular group’s strident opposition to “putting people in boxes,” but it exposes something important about predicament they are in. On the one hand, the service has been contracted to deliver

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<sup>50</sup> The Mental Health Clustering System is based on an NHS tool developed for care providers to rate the combination and severity of needs, based on their routine screening and assessment process at the point of initial assessment or a moment of change in care. The “levels” of need underpinned how services were commissioned and was used to differing extents in the clinical decision-making of each service.

a talking therapy that promises to be “evidence based” and to select service users according to a standardised idea of what kind of need they might reasonably be expected to meet. On the other hand, however, the whole value system and rationale of the intercultural therapy centre is based around being sensitive and responsive to *different* needs. *Doing things differently*, in a general sense is not just a principle or a value in their work; it is their unique selling point and means of financial survival when it comes to securing contracts. How else, but by offering such a specialised multi-lingual and cultural service, could they compete with the evidence-based efficiency of CBT services? As the meeting drew to a close, an exasperated Miles explained this point to their (by then equally exasperated) visitor, “we are *not* an IAPT service; if we were, the commissioner would say to me, ‘I don’t need you, I have an IAPT service.’”

In order to prove the service was having an impact in *different* ways to what the recovery rates showed, it was necessary to defend and justify delivering therapeutic work that might not get further than understanding or “bearing witness to” (as one therapist put it) people’s needs. Such defences ran through many small mundane channels of communication between providers and contractors. A rushed email, circulated around one centre on the brink of losing a Charity Impact Award because they were falling short of the recovery target, arrived in my inbox early one morning. The request for explanations “off the top of [therapists’] heads” had produced a cogent list of the aspects of need that could not be contained by the IAPT-defined categories such as “level two depression”:

...2. The issues faced by a number of our clients are rooted in socio-economic factors. These factors can be poor housing, unemployment, poverty and these factors are reflected in how their distress/symptoms manifest.

3. The complex cases presented here, often by clients who are seeking not only a waning in distress or symptoms but in the search for a credible witness to their traumatic stories and experiences...

...and so on. Shot through these summary points, buried in a thread of forwarded emails, was an insistence that “need” often spills out of the confines of observable depression symptoms and measurable levels of severity, into the realms of the socio-

economic and biographical: what these therapists would often call the clients' "external realities". This apparent overflow and limitlessness of need was made particularly visible by the infamous "IAPT box." In Part II of this chapter, I revisit this tension and examine the creative ways it was managed in clinical and organisational practice.

### *Doing need discursively*

In discourses of *doing need differently*, such as those in the talk and text I have described above, "need" is framed as inextricable from the "external realities" of people and their communities. This non-medical, community focused approach can be pitted against a discourse about "the mainstream" that sees need as intra-psychic, and understood in terms of the dysfunctional thought processes that could, for example, be treated with cognitive behavioural therapy. In the case of Culture in Mind, from which I have drawn the examples above, mental health need was seen to be tightly bound to external realities of dislocation, discrimination and intersecting socio-economic factors. Similarly, therapists at the Pankhurst Women's Centre would be attuned to these same issues around migration and dislocation, as well as their specific gendered dimensions. Finally, the Stepping Stones Bereavement Service works on the assumption that need arises with a particularly complicated or distressing grieving process; when the "normal" experience of another person's death becomes entangled with the difficulties of one's own life. Discourses around need were thus embedded in specialised understandings of these external realities, often because of personal experiences of being a part of the communities they serve. Therapists' talk about need therefore strengthened the dichotomy between the within-person focus of *mainstream need*, and this more politicised, holistic means of *doing need differently*.

Other dichotomous framings of *mainstream need* versus *doing need differently*, which surfaced in various ways from the talk of staff and volunteers across all three sites: "they" (the NHS) works with a general population, whilst "we" (voluntary organisations) provide for a specific client group or community; "they" recognise mental health need using the tools and training of the medical professions, whilst "we" recognise need through interpersonal dynamics; "they" consider need as something to be measured (even when it cannot be fully understood), whilst "we" see

need as there to be *understood* (even if it cannot be measured with NHS or NICE approved tools). A lot rested on maintaining such distinctions. Recall Miles's cautionary note that if his organisation conformed to the same inclusion and exclusion criteria as the IAPT services that they were commissioned alongside, they would no longer be of use to the community they served and would lose their contract. In similar ways across the discursive spaces of these voluntary settings, it was necessary to highlight a certain kind of *difference* and *specialism*, so as not to become muddled with the mainstream, falling into the trap of being unfairly evaluated against their standards (which assumed a great deal more resources to treat for a much simpler kind of need). The set of "ideal type" distinctions that I have recounted above helped with this, but often they were hard to maintain.

In the following section, I take a closer look at how these dichotomies would "hit the ground" to find a host of competing values about the way need should be constructed. In the ethnographic scenes below, I seek to demonstrate that there is no pure space in which a single set of values can be put into practice; rather, need is practiced through laborious processes of negotiation and compromise. One feature of these discourses "hitting the ground" was the way they were operationalised within administrative practice. I have raised the question of how absent diagnoses might be made into "something else" – a different articulation of need. Making absence into presence is often talked about as something being "made visible," but this doesn't speak well to the enactment of need, which never takes shape or becomes something solid that one can see. I prefer to talk about need being made *legible*, in order to understand it as a recognisable entity. "Administrative legibility" (Matza 2018, 152) is a useful idea, because it speaks to the bureaucratic requirements of enabling access to care, and to the painful compromises that I describe playing out in the scenes below.

## **II. Negotiating need**

### *Scene I: Spilling out of the "IAPT box" (continued)*

The pre-assessment screening again: we are in the communal workspace of Culture in Mind. K and I are eyeballing the list of what she has earmarked as potential "IAPT-plus" cases: people who require culturally sensitive therapy but who may not "recover" in 6-12 sessions. This sentence catches in my mind, the reasoning behind

it still unclear to me. It's not the first time I have heard the term "IAPT-plus" but it is the first time I have seen it put to work. K explains to me that only one in five cases are allowed to "be IAPT-plus," the rest must be treated as "normal cases". The parameters of need in a "normal case" were initially set by the local clinical commissioners according to numeric "cluster levels" and diagnostically defined "common mental disorders." But it became clear (apparently even *within* the IAPT programme) that there were people presenting with needs that went beyond what was appropriate for a normal IAPT case but did not have access to secondary mental health services,<sup>51</sup> usually because they did not have the right diagnosis. Most visibly (at least here), these seem to be people who have experienced adverse or traumatic life events, due to migration experiences or other forms of cultural dislocation. IAPT-plus had been designed to capture cases like this and allow them to access talking therapy. After the stand-off about the limitations of the "IAPT box," and other appeals for more generosity in the way appropriate need was defined and monitored, the IAPT-plus category was made available to Culture in Mind and organisations like it. The only problem is that we have been told it may only be applied to a maximum of one in five of all the referrals. Three out of the nine referrals in this screening session is too many, but none are excluded from going through to the waiting list for full assessment. The decisions will be put off until later stages of the assessment and allocation process. By then we will know more about who is most likely to benefit from the therapy, who may or may not be able to turn up to their sessions every week, and who has already dropped off the waiting list for missing two or more assessments.

The strangely permissive "overspill" category of "IAPT-plus" was pivotal to the negotiations about what kind of need the service could address under its contracts; it opened up more possibilities for legitimately taking on people whose need could not be met under the standard IAPT framework.<sup>52</sup> Crucially, the category was designed for those people who were likely to benefit from the service but would not necessarily recover. The fact that the 50% recovery rate target was not being met here—or in

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<sup>51</sup> The outcome of a clinical commissioning group meeting that year, assessing mental health service provision in the local area.

<sup>52</sup> These complex problems are described in the report that came out shortly after this was taken up on the Effectiveness of Improving Access to Psychological Therapies (IAPT) and Similar Services as: "longstanding complex problems of depression or anxiety, often associated with *major adverse historical and/or current life difficulties*, and co-morbidities, such as personality or *relationship difficulties*, or long-term physical health conditions and medically unexplained conditions (emphasis added) (Galczynski 2017).

any of the centres I worked with, for that matter—was no secret, and was often taken as validation of what they already knew: that the problems they addressed with their clients were unlikely to be solvable in their time-limited sessions. But this was a means by which therapists, evaluators, and the commissioners could legitimise identifying and addressing need without the promise of recovery. The category was necessary because of the impossibility of “meeting” needs relating to homelessness, statelessness or on-going domestic violence in twelve sessions, which would bring down the recovery rates if they showed up on the IAPT monitoring system. Like most negotiations between big contractors and small sellers of services, however, there were conditions to the deal that got struck as a result. The fact that the application of this category covered only a maximum of one in five clients left the assessing therapists in a constant state of compromise. Whilst workable, and in many ways effective, it seemed a somewhat limited solution to the problem of need that is (according to these therapists) potentially *limitless*: un-meet-able in twelve sessions, and reaching far beyond the inner world of the client.

This negotiation harks back to the riskiness of articulating need according to diagnostic categories and the way it exposes these services to damning evaluations further down the line when the effectiveness of the therapy is monitored with a mainstream system. Wilfully creating this space of indeterminacy helped to avoid bounded notions of mental illness from which one can “recover” or indeed remain stuck to. Yet *still*, need had to be made legible, to be transformed into an administrative reality of eligibility criteria. Here, then, need was produced *vis a vis* a particular kind of difference. Recall the cases that K highlighted in the opening vignette, highlighting certain parts (country of origin, immigration status, childhood experience and so on) and bracketing off others (the label of PTSD). Here, need was made legible *vis a vis* cultural difference or extraordinary life experiences of trauma and dislocation, rather than being made legible as an illness category with its own specific clinical criteria. The diagnosis was made absent but need was still made legible, in relation to cultural *difference*.

### *Scene 2: Negotiating upper and lower thresholds of need*

I am sitting in on an assessors’ meeting, this time at the Bereavement Service. Sian is leading the meeting, but the discussion—over strong breakfast tea and a table

smattered with the crumbs of digestives—feels relaxed; this is one of the few chances in the month they are able to do this “catching up”. They are talking about the enormous range of different people who come into the service these days, often stratified by the time of day their sessions fall into. Marion works in the evenings and sees clients who tend to be high functioning professionals and sometimes even willing to pay for the service on a voluntary basis. Ralph works during the day, meaning his experience of the clients is the “exact opposite.” Sarah concurs with Ralph, but her tone is less breezy, less inquisitive than his. She also works during the day, and has become uneasy about the kinds of problems she has been seeing in her assessments and regular sessions recently. In addition to their experiences of bereavement, one client is very paranoid, another has severe panic attacks that stop her getting to the centre some weeks... As she trails off, Sian (as Sarah’s supervisor) interjects with a question about how this came about and wonders whether the assessments could have been done differently, implying that a different conclusion may have been reached. Sarah thinks back to the last client she mentioned, eyes raised to the ceiling. “Well, it was clear from the clinical notes from [the referrer] what the issues were, but we were never going to turn them away.”

Ralph turns to me, knowing that this is something I am interested in, explaining gently that, “Once someone has come through the door here, we hardly ever turn them away. So in a way, the assessment almost isn’t there to decide if they’re appropriate.”

Sian shakes her head ever so slightly, waiting for Ralph to finish. Then she changes tack from her exploratory questioning, and, looking pained, leans in with her palms flat on the table, insisting, “but it *is*. The assessment *has to* be more discerning now. We *can’t* take everyone in.”

This moment of disagreement within the assessors’ meeting embodied a paradox in the way that this service had to work at that time. Sitting alongside, and in tension with their longstanding ethos of keeping “open doors,” the staff were having to think seriously about how to manage the increasing volume of people being referred to their service, and the severity of the problems that they were coming to them with. This theme emerged uncomfortably intertwined with the “dumping ground” metaphor I explored in detail in chapter 4. What had been a policy that was deeply bound up with their principle that bereavement counselling was open to anyone, was now threatening to “sink them,” as a concerned outsider from another member of the consortium put it. Again, metaphors of survival and disaster quickly creep in to

talk about the boundaries and capacities of these spaces of care. I was told many times that the change was (at least in part) a fallout from the cuts to mainstream secondary mental health services over recent years. More and more people who had suffered a bereavement but had had additional, often pre-existing and severe mental health difficulties, were being referred to the service rather than to the NHS for more intensive treatment.

The service had become more and more professionalised as a result of this over the years, a move away from the era when they would provide induction courses for untrained volunteers wanting to offer community-based counselling. As the client group changed, the service adapted: a neat echo of the supply and demand logic the commissioning system is rooted in, perhaps. But not quite. The principle of supply and demand in health services suggests that services respond to need “in” individuals “out there” in the communities they serve. The therapists and other staff members I was talking to were acutely aware of the heightened levels of need they had become responsible for attending to, but they almost never put this down to changes in the community itself, but rather the changing (and increasingly sparse) landscape of “supply”, of which they were only a tiny part.

The practical challenges of this shift in responsibility threw the hard work of *negotiating need* into sharp relief. The Bereavement Service’s version of “doing need differently” revolved around a normalisation and de-medicalisation of grief and loss: “everybody in the end, if you live more than a week, has somebody that dies—it’s part of normal life!” A quote from Gail, an administrator, who reminded me of this during an interview in which I was probing about her declaration that the service was for “Anyone.” She went on to say that whilst bereavement is normal, what makes people come to the service is their *complicated lives*. Like in the first scene at Culture in Mind, I observed a kind of “spilling over” from a narrowly defined concept of need as internalised disorder, to the external realities of living and, of course, dying. This time, however, these external realities were not so much focussed on the minority or marginal experience as on experiences that were potentially universal. There was an insistence that this particular expression of need is not only *normal* in that it is not pathological, but also in that it is *universal*: “people die, that’s life!” (Gail again). But how was the service to remain, in principle, for “Anyone”, when an increasingly

large proportion of their clients were coming to them with needs that were (according to the service's contracts, at least) too severe to be addressed by volunteer bereavement counsellors? Who is "Anyone", when the upper and lower thresholds of need were pressing in on the eligibility criteria for the service?

*Needy enough/not too needy*

A balancing act was taking place, which was arguably unsustainable, but the only way in which therapists could enact need according to the organisation's ethos. Therapists and administrators took seriously the limited capacity for absorbing the new more severe need they were encountering whilst *also* working to make anyone they believed would benefit from their care eligible for it. The thresholds for eligibility were set largely by their NHS contractors through the "Mental Health Clustering" system, which determined the level of (potential) clients' mental health need calculated by screening tools for anxiety and depression. Assessors often had to manage a mismatch between their clinical judgement and the scores on clients' forms. A woman falling short of the lower threshold for being an eligible "case" for the service made Sian exclaim as she pulled out an intake form she had been searching for in the filing cabinet: "I know damn well that this woman's problems are not being captured in the form." Waving the thin yellow sheet in front of her, she went on, "She's the kind of woman who wouldn't want to make a fuss or worry anyone, so she appears like this on paper." Sian announced there and then she was going to roll out a training on this—how therapists can encourage clients to "express what they need," in order for them to access the help the service offers. The negotiations of paper-based thresholds played out at the upper-end too. In a training session on how to "cluster" clients to assess eligibility, there was talk of doing the forms orally for clients who were scoring "too highly" because of the stress of filling in the forms. Experienced therapists were very willing to put the "art" of their clinical judgement over the "science" of standardised guidelines to accept people who were technically too severe but whom they felt would benefit from their therapeutic care.

The necessity to limit the enormous range of different needs the service attended to risked undermining the Bereavement Service's version of *doing need differently*, in that it made it increasingly difficult to practice the ethos of opening their doors to anyone and everyone. In response, staff members who found themselves in new gatekeeping

roles continuously negotiated these upper and lower thresholds of what constitutes “appropriate” need (needy enough, not too severely needy). This was not a case of “breaking the rules” or disregarding the need to ensure that the service was not taking on people they could not help; rather, a whole set of actors, including Sian, the trustees, and assessors coalesced around the problem and the paradox that became something of a public secret: that whilst the service was supposed to be for “anyone”, it “could not take everyone in.” Making people eligible for the service involved paying constant attention to where needs may have been over or under estimated by clinical tools and adjusting for this accordingly.

“Need”, in this case was being enacted in a dangerously porous environment, which nevertheless had limited capacity. Assessments and articulations of need emerged in surprisingly technical forms and in increasingly bounded (if artificially so) ways in order to manage this. The understanding that death and loss is part of “normal” life meant that *doing need differently* was about constantly managing and limiting the many forms of loss experienced by a growing range of people—not according to specific pathologies or categorisations but rather through levels of “appropriate” need. And so the adjustments of eligibility criteria, such as where people fell within the clustering system, were about carefully containing limitlessness, in contrast to the scene I described above, which was all about permitting it. Need here was produced *vis a vis* de-medicalised but nevertheless “normal” experiences of human life and death.

### *Scene 3: Negotiating ‘Other’ classifications of need*

The unwieldy sheet of paper, which is usually stuck to the wall of the administrative area of the Women’s Centre, has been extricated from the pin board and brought into the clinical meeting. The document, containing a chart of all their funders and contracts, is treated with a sense of distain; it is a representation of the fragmented and scarce funding landscape they must navigate in order to carry out their work. It seems to have grown since the last time I saw it. Melek battles with the sheet of paper on the small round table she is leaning on, amongst the piles of slimy plastic wallets, which hold all the client files that need to be discussed. It would be their reference point throughout the meeting, laying out all the names of their funders, how many sessions they would fund for each client, and—crucially—what kind of women they were providing funds for. An example: for the NHS contract, the criteria might tell them that *if* she is of BME (Black and Minority Ethnic) background, has experienced

childhood sexual abuse *or* domestic violence *and* is registered as a resident of the relevant borough, *and* there is money left in that funding stream, that woman would be eligible for 12 sessions of one to one therapy. If any of these criteria are not met, the therapists around the table will run their fingers down the left-hand column of the chart calling out names of alternative private sources of funding and then asking if the client could fit into their criteria: the Refugee and Asylum Seeker Women's Project? Young Mothers? Trafficked Women? Much of the allocation process hinges on whether they can fit the woman into one of the boxes in the document.

There are many cases to cover today, after several of weeks of sick leave from the clinical services manager, and the loss of the main volunteer administrator (who is perhaps the only staff member who has a constant handle on the on-going influx and management of new clients—remembering all the names and backstories by heart). The room is hot and the meeting already feels chaotic and difficult. The first case: a woman that has been earmarked for the 'Empowerment and Access' funding stream. This fund, for women with chronic illness and disability, is known for being notoriously easy to shoehorn almost anyone into, if they have a mental health problem that can be described as disabling. But according to Nour, who assessed her, she is very high functioning and just wants to explore some "interpersonal dynamics". They start thinking about how to place her, if not according to a disability framework. "Is she a refugee?" asks D, hopefully, finger on the A3 sheet. "No, she's Austrian," says Nour. "Ok well then how about..." She suggests some streams that don't focus specifically on BME, but more generally on "socially disadvantaged" women. Then someone interjects by asking again if she really is "socially disadvantaged." Slowly it emerges that the woman is in fact "loaded" (or at least has much more money than the other women who access the service), and has had nine years of psychotherapy in the past. They all decide that Nour should liaise with the woman and tell her she is sorry but she "doesn't fit into the category" of people the Women's Centre provides free therapy for.

Before we get to any further files, Paulette, who is not a therapist but in charge of much of the fundraising at the moment, asks to join the meeting. She wants to talk about unmet "targets": the number of women they have been funded to provide therapy to but haven't yet seen.

"Do we have any BMEs? We are lacking them! We need BMEs..." she is half-joking, putting on an announcer's voice through a pretend loudspeaker to acknowledge the slightly farcical nature of the request. I know, from our endless

conversations about the politics of these categories, that she feels able to make light of this one, particularly as a black woman who would fall into this “BME” box herself. But at the same time she is entirely serious; she needs some more women who can fit this category otherwise she won’t meet the target number of women for that funding stream. They move on through the pile of cellophane files and before long they encounter a case that is “complex,” which means, in part, that she is hard to allocate. Paulette pipes up again: “is she BME? What’s her name?” They look it up... “She’s Chilean! Yes!” someone remembers, and finally it is confirmed after much thumbing through the woman’s bundled-together clinical notes. Once the women finish rolling their eyes at the drama of all of this, they can allocate the (now eligible) client to a therapist and offer her twelve one-to-one sessions. They move on to the next case.

This scene gives a glimpse into the pitfalls involved in translating *different* ways of *doing need* into an administrative reality. The realm of private, charitable funds brought a whole different set of problems for the assessors to work around. These problems were not exclusive to the site I have just described but were particularly pertinent there, as they obtained a smaller proportion of their funding from NHS contracts than the others and relied more heavily on charitable sources of income for their work. This relative freedom from the NHS and reliance on alternative sources of funding was a double-edged sword. It allowed them, for example, to provide up to a year of therapy to some women—something that was unheard of under NHS contracts—and carry out the community-based outreach work with migrant and refugee women I described in chapter 5. It was also, however, a large part of what drove the fears about the *fragmentation* and *dilution* of the therapeutic work that I described in the same chapter. The set of problems I want to explore here (which are different but interconnected to those ideas that I previously described in spatial terms) are about the new set of “boxes” that must be negotiated in the fragmented charity funding landscape. Specifically, the new sets of categories that get enacted once the argument that *different kinds* of people have *different kinds* of needs become formalised and translated into yet more eligibility criteria for accessing care. The cynicism that surrounded this ritual with the unwieldy funding chart was part of the work it took to “bracket off” this hazardous side effect of the Women’s Centre’s means of *doing need differently*.

“Difference” in this milieu was largely defined by a bewildering and fragmented set of funder-driven “boxes.” Part of what made the process of reviewing assessments and making allocations in this way so gruelling was the imperative to “pin down” the kind of need in crude enough terms that it could be allocated to one of these boxes, and thus, to a funding stream. The funding chart provided an almost cartoonish representation of discrete social categories of need, which facilitated this pinning down: “disadvantaged women,” “survivors of gender-based violence,” “trafficked women” and—troublingly, when put in these terms of self-evident or intrinsic need—“BME”.<sup>53</sup> Whilst this particular meeting revolved around making practical use of these funding “boxes”, it would be a mistake to say that these practitioners wholly or uncritically subscribed to this system of categorising need. For them, the labour of *doing need differently* involved not just the negotiation of IAPT-defined parameters of need, or upper and lower thresholds of appropriate need, but *also* this assortment of funder-defined social categories. The pitfalls of replacing one set of reified categories of need (diagnostic) with another (funding-defined), was something that many of the therapists were acutely aware of. Reflecting back to the clinical team my observations of therapists’ dissatisfaction with funding-defined categories, I was met with the blunt, rhetorical question: “Is there really any difference between the NHS diagnostic model and the charity funding framework?” So despite the air of pragmatism that accompanied much of the clinical and administrative decision-making, these multiple forms of negotiation were a constant burden. They also made for tough, often inefficient work.

Therapists at this centre found themselves making need legible and legitimate *vis a vis* a less-than-ideal and largely funder-driven framework of difference. In order to resist “pinning down” need entirely within this framework, these women would craft spaces of indeterminacy. At times this involved them *spreading out* statements of client need (temporally and across documentation), and at other moments, *gathering together* eclectic categorisations of need in one place: As I was often reminded, there was no single moment of “diagnosis” in the assessment process at the centre, though there were several points at which the kind of need was partially, temporarily or

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<sup>53</sup> As much as this category of “BME” was used as a shorthand for recognising the disproportionately low levels of access to psychotherapy across non-white, non-middle class groups, it was never explicitly suggested that being in the “BME” category (as almost all the therapists were) made you inherently “needy.”

provisionally articulated by therapists or administrators. The assessment and allocation meeting was one such point in the process of *spreading out*. Other points included the “presenting problem” (a record of the client’s first expression of their needs) and the longer, “clinical formulation” (the outcome of the assessment). Later on in the meeting I described above, when the women had grown frustrated with the constant back and forth between these different sources, someone came up with a suggestion: that the assessors come up with a “one-liner” to write at the top of each case to summarise the “outstanding issues” to help fast track them to the most appropriate funding stream. In fact, I was more conscious of the growing proliferation (rather than consolidation) of different administrative spaces to document need, and doubt that this was ever taken up as a simple solution to this problem. But the fantasy that they might summarise these vastly heterogeneous issues in a “one-liner” exemplifies a second strategy for avoiding the pinning down of particular needs: of *gathering together* different, eclectic forms of need. This was already a feature of all the existing assessment documentation, and it was hard to imagine a more composite set of descriptors. One “presenting problem”, read out to me from an assessment form, frankly itemised “trauma, sexual abuse, rape, moderate depression, anxiety.” As such, the “presenting problem” alone could contain an array of problems, holding together clinical, biographical and social categorisations of need.

The loose, aggregate statements of need, and the different points at which need was articulated, formulated and recorded, which all emerged from these practices (of spreading out and gathering together), maintained a somewhat elusive space in which need could never quite be pinned down, and much less be reified through any one system of categorisation. They created important spaces of indeterminacy, which countered some of the “box-like” qualities of funder-driven need. *And yet*, this took a huge amount of work, which at times was hard to manage without the technical support of paid administrative staff, ironically creating *more* paperwork, box-filling and preoccupation with “the system” more broadly. Producing need as something legible *and* indeterminate was perilous—nearing impossible—in this particular centre. This was largely due to the fragmented and funder-driven mode of “doing difference” that characterised the organisation at that time.

The negotiations were particularly fraught in this setting, but I have been arguing that in *all* these scenes of negotiation, the forms and articulations of difference are crucial to understanding the process of enacting need. *Doing need differently* cannot only be understood in relation to the mainstream, but also in relation to forms of difference within a particular milieu. Put slightly differently, *doing need differently* is not done only in opposition to universality, but also in reference to particular forms of *differentness* (a theme I explore further in my discussion chapter of this thesis). Far from being straightforward, more authentic alternatives to diagnostic categorisations of mental health need, these enactments of need were troubled by the bureaucracy, limited capacities, and competing interests associated with this *differentness*. In the next part, I discuss a concern that underpinned many of these problems in the bureaucratic negotiation spaces I have been describing.

### **III. Where is the *human in need*?**

The scenes I have explored above have animated three aspects of the work, negotiations, and perils that go into maintaining space for alternative ways of “doing need.” They focused particularly on the decision-making processes about eligibility and the inclusion or exclusion of incoming potential clients. More specifically, the improvising and hustling which therapists did *on behalf* of the men and women accessing the service, whom they understood to be in need. Where were these men and women in the negotiations? Was there some part of them “in” the clinical notes, the discussions, the emails, the (non-)recovery rates and so on? More interesting, perhaps, is the possibility that they were in some ways “made up” in the processes of managing, containing and gathering together various categories of need (Hacking 2006). All of these ideas are likely to be at work here, but I want to dwell on a much simpler observation: of the absence of the living *human-in-need* in all these discussions. There was, as I have described above, an all-important assessment session of fifty minutes, which served the precise function of an assessment of need, and which was highly valued by clients and therapists alike, for its therapeutic value as much as its function in gatekeeping. However, I have made a choice to focus on encounters and discussions whose subjects are nowhere to be seen, kept at bay with waiting lists and other administrative functions. Their absence is important to note, because it is a

reminder that this is a particular story of the way that needs were enacted in these therapy centres.

*“Once I have a human being in front of me...”*

People, human interaction, and humanness in general, was foundational to the values of these centres. For example, the trope of *not treating people like numbers* was important in all my field sites. It often came up in day-to-day talk and was almost always used in reference to mainstream institutions, whose client groups were so large that (it was implied) people would be treated as no more than a number or a statistic. In these smaller, community based sites, *humanness* and *treating people like humans* was one of the ways in which they distinguished their practice from that of mainstream providers. And yet, the work that I have documented here has been the work of *doing need* in the absence of the individuals who live and feel that need. This tension emerged as I became aware of a split in many therapists’ work, where they would operate according to two parallel registers about the clients or potential clients they encountered. One register (predominant in the scenes above) referred to the abstract terms of “communities”, “client-groups”, or “cases” not yet engaged in therapeutic relationships; the other referred to the *people* that they encountered once the access process was complete and regular contact was being made in the therapeutic space. The latter seemed to speak to this idea of the cherished role of *the human* in these spaces.

I reflected this tension back to a group at the Women’s Centre, in which the therapists bore much of the responsibility for the administrative work of facilitating access to the service. The observation in this particular feedback session struck a chord, eliciting nods of recognition and bids to share personal interpretations of this pattern. Jehona, who ran the refugee project, explained it in terms of shifting between two terminologies of “targets” and “human beings,”

For me it’s like shifting between the two... once I have a human being in front of me, I treat them as a human being, but there’s a different part of our work which requires me to call them “trafficked bla bla.” Now it comes naturally to me, this shifting.

This echoed around the accounts of others: negotiating need as eligibility criteria felt like “playing the game” of contracts and funding, and there was talk of a pragmatic approach to “working the system,” but all of this was pitted against a *different* way of working *in the room* (by this they meant the therapy room). This latter way of working was the other, more difficult-to-narrate part of the story of *doing need differently*. Was this where the ‘real’ doing of need took place? I don’t think so. Need was negotiated and made legible in the scenes and discourse I described above, and was thus made real in *different* ways, in different kinds of environment. But I am compelled to take seriously what all that negotiation seemed to be *for*: the moment of having “a human being in front of me,” when all the game-playing and pragmatism can (at least potentially) be set aside. I would argue that it is more productive to understand this in terms of ethics than ontology: that these therapists’ concern was less about whether a particular need was *real* than it was about knowing and enacting that need *ethically* according to their logics and values of care.

*(When) is need non-negotiable?*

Therapists’ commitment to the human encounter, in which need is un-bounded, dynamic and always related to the “external realities” of clients, pertains to the third way in which need comes into being. This is different to both the *doing need discursively* described in the first part of the chapter, and to *negotiating need* in part two. It is also closest to the vitalist philosophy that need cannot be pinned down by mechanistic explanation and categorised as a fact; rather, it emerges from the relation between the individual and its milieu. There seemed to be intrinsic value to this human encounter and it was no surprise that service users and providers strived for this one-to-one space where need could be seen as emergent and unfixed. But the *problem* that they constantly faced was that this kind of need is illegible beyond that therapeutic encounter. The need may be produced *vis a vis differentness* rather than *universality* in the therapeutic encounter but this differentness could take an infinite number of forms. This milieu was therefore less productive in creating eligibility than the more bureaucratic scenes of negotiation. What I am talking about here is need as it is lived and felt by people, compared to the representations of need as they were being negotiated by others, at a distance. Again, I would say that these different articulations of need are more than “real life” *versus* its representations: the *relationship*

between life and knowledge was also something of key concern within Canguilhem's vitalism (1952/2008) and plays out vividly in this material. The questions around need and its representations in this chapter animate this difficult and always imperfect relationship. It is in these terms that I want to acknowledge the tension between the way in which therapists and clients would *do need* in these more intimate client-therapist encounters and in the negotiation practices I have been describing.

I was not there to witness these intimate moments of shared client-therapist decision making within assessments, but the encounters, as they were described to me, by both clients and therapists (and as I recounted in the previous chapter, through Samira's story) were not characterised by the language of compromise, or "playing the game," of the allocation and funding discussions. Unlike the negotiability of IAPT or funder-defined models of "appropriate need", there was a sense in which a person's need became self-evident at those given moments. As such, it could not be "pinned down" and recorded indelibly as any one "thing" on the assessment form, but in those moments, need would emerge and become—if only temporarily—absolute. What I understood from both clients and therapists was that *in the therapy room*, need was non-negotiable and taken at face value. For clients, the negotiation and questioning took place at different moments: the GP, the Home Office, the hospital; for therapists, it took place in clinical meetings such as I have described in the ethnographic material on "negotiating need" above. This enactment of dynamic, but non-negotiable need is the goal of *doing need differently*, an embodiment of the values that guide this practice. However, I have been arguing that the work it takes to uphold these values introduces another, messier, more uncomfortable aspect of *doing need differently*. And so, whilst need may be non-negotiable at certain moments of feeling and witnessing in the clinical encounter, the data I have presented in this chapter demonstrates that the enactment of need goes beyond this clinical encounter. The work, negotiability, and perilousness of *doing need differently* outside of the therapy room tells us that there are multiple and often competing values and interests involved in the enactment of need.

## **Conclusions: A compromised ethics of inclusion**

Taken together, these ethnographic data animate various iterations of *doing need* in my three field sites: the *discursive practice* of performing the values that underpin the assessment of need, the *work and negotiation* it takes to enact need legitimately yet differently to the mainstream, and (mostly invisible here) the moment-by-moment *dynamic emergence* of need in the clinical encounter. Each of these shows the production of need within a milieu but with different tensions and entanglements between lived and known need: the painful tension between indeterminacy and legibility being central to this.

In this chapter, I have turned my attention “inwards” at the specific architecture of each of my field sites, in contrast to the previous chapter where I focused on more general relations with “the mainstream.” I have focused most intensively on the second aspect of *doing need differently*, myself labouring over the (sometimes tedious) scenes of negotiation, where the specific values of each organisation must be defended, but also compromised to make need knowable, visible and administratively legible. I have focused on these scenes of negotiation, not to suggest that this particular enactment of need is “most real,” but to shine a light on those practices and spaces in which need is a) most labour-intensively produced, and b) most *productive*, in terms of what it does for people in the bigger story of accessing and enabling access to therapeutic care. Much of what is laborious about this process of *doing need differently*, is that it performs important boundary work between these voluntary organisations and an ever-encroaching “mainstream.” This speaks more broadly to my arguments in the first part of this thesis, about the making and remaking of the “surfaces” of these places: their boundaries, porousness and relations to the wider system of care. More crucially for the users of the services, however, these scenes of negotiation are where decisions get made about what constitutes need in general, *and* who, specifically, is eligible for care.

In these scenes of negotiation, need was enacted *vis a vis* certain forms of difference, which was largely what defined these centres as alternative spaces of care. Each centre had its own architecture of differentness, which emerged out of a complex set

of values and interests—both internal to each organisation, and coming from the mainstream. These values and interests were made most explicit in the second part of this chapter, where I described negotiations that revolved around the constraints that therapists and administrative staff found were placed around their ideal ways of doing need, from “the outside” (be it NHS commissioners, IAPT monitoring frameworks, or charitable funding streams). This was a manifestation of their positioning on the peripheries of the formal mainstream mental health system: in many ways dependent on it, but at the same time having to remain *always different*. Need was therefore enacted *vis a vis* their own values (of *doing things differently*), as well as in relation to the values and constraints of the mainstream. Adopting the overspill category for the IAPT monitoring system, tinkering with the upper and lower thresholds of mental health “clustering” set by contractors, and negotiating multiple funder-defined “boxes” of neediness, were all ways that this played out in the bureaucratic, but affectively charged environment of clinical decision making. In this way, need only came into being *in relation* to values and articulations of difference, within a given environment.

I have been arguing that this administrative, bureaucratic environment was a surprisingly productive space, because this is where need was made *legible* and in turn, made people eligible for care. Unlike the abstract discursive space I described in the first part of the chapter, or the intimate one-to-one therapeutic space in the last one, this was where need took shape as an administrative reality, rendering people eligible as recipients of psychotherapy. In the discussion section of this thesis, I raise the issue of when need becomes more or less legible within a wider context of national or even global matters of concern.<sup>54</sup> But here I want to shine a light on the more immediate and situated *costs* that come with this labour of inclusion. When *doing need* was performed in dialogue with multiple constraints and precarious relationships with funders, it could never be a pure enactment of the values that therapists strived to uphold. All three scenes showed actors employing less-than-ideal parameters of need,

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<sup>54</sup> Of note here is the way in which Culture in Mind was able to use the “IAPT-plus” category to include certain people with severe or “limitless” need through logics of cultural difference and migration, whilst the other services tended to have to make the case for each individual, under much more fragmented systems of defining their differentness.

which they then negotiated and reconfigured—often seeking out spaces of indeterminacy in order to make more inclusive, less “box-like” criteria for eligibility.

This chapter has destabilised the notion that by *doing need differently* to the mainstream mental health system, these care providers are enacting a somehow “more real” need, or one that is less mediated by categories and bureaucracy. However, it does show that these practices are able to produce a more generous, permissive, and ethical mode of articulating need, embracing rather than trying to stamp out indeterminacies. There is a strong ethics to this: an ethics of inclusion. But putting this into practice does not come without cost. I have shown that the *labour* of inclusion is full of perilous negotiation and compromise. Most perilously, it is possible to lose sight of “the-human-in-need,” even when this is central to the values and ethos of the provider of care. Whilst at any given moment a need may be absolute, so much of the work of enacting need I observed was about making need negotiable, knowable, and legible.

## Chapter 9: Discussion and Conclusions

“the milieu proposes without ever imposing a solution.” (Canguilhem 1952/2001, 17)

A year or so after finishing my fieldwork, I push the door open once more and step into the familiar space of Culture in Mind. I had received an email from Miles the week before: there’s someone he’d like me to meet. The place looks and feels simultaneously the same and different. The hotel-lobby waiting room is looking more “homey,” having acquired a small jumble of toys in the corner and some more chairs, but otherwise not much has visibly changed (to my embarrassment, an image of my face, on the poster I made to inform people about the visiting ethnographer at the service, still hangs from two pins on the crowded notice board). I know the door-code, but I don’t use it this time, instead waiting to be buzzed in and greeted as a visitor: hugs at the door, a mouthed “hello” from one of the therapists down the corridor, hovering at the reception until Miles comes out of the meeting room with a young woman, about my age. He introduces her as a doctoral student, interested in specialised psychotherapy services and questions around culturally sensitive mental health care.

As we finish introductions and sit down in a triangle in the meeting room, I ask about what’s new, hoping to get a sense of the real changes that have come to pass over the year. I am told that the most recent clinical manager has had to leave because, as one of the few paid staff, they could no longer afford to keep her on. I imagine this to be a disaster (who will be the point of contact for all volunteers and trainee therapists? Who will push back against demands from the commissioners that regularly undermine their therapeutic approach?) But I hear that the staff are getting on with things and the trustees are unfazed: “we have been in this position before and we always survive,” they say.

As we talk about the commissioning contracts that have been renewed and those he is worried about, the student interrupts us “so *is* this part of the NHS, then?” Miles sighs and says, “no, it’s not, but it’s a good question. We are mainly funded by NHS contracts, but we will always be a charity...” I chime in, explaining what I had learned early on about the history of this organisation, and others like it: that the founders had all wanted to develop therapeutic models that would eventually be

taken up into the NHS. We talk about the current situation and how it is ironic that they remain so different from the NHS but are actually closer and more dependent on the mainstream system than they have ever been.

“But” says Miles, “it’s important to people we are not a mainstream clinical setting” he gestures towards the hallway outside; “they come in here, we’re a bit different, we’re not like a hospital or the doctors...” He sighs, repeating her question: “Are we part of the NHS...? Well, the NHS is *so fragmented* now—maybe we should be asking, ‘what is the NHS...?’ even before we ask ‘what are we?’”

There was something uncanny about this non-ending to the project, something cyclical about the way another interested researcher had found her way to this centre and was navigating her way around its nebulous relationship with the thing we call the “NHS.” It feels apt to conjure this sense of an “anti-ending,” as Anna Tsing has called it (2015, 277), to remain true to the sense of “muddling through” with people in precarious times. By attending to another beginning, I do not mean to suggest that things will simply repeat themselves. This encounter made me acutely aware of the increasing fragmentation of the NHS, but also of the shifting relationships between the third sector and mainstream, the transitory nature of the service as I had known it, and the constant adaptation that must come with surviving in their position within this configuration. The tension I identified in the introduction—between the universalist policies of IAPT and principles of specificity, competition and choice in third sector commissioning—epitomises the age old push-pull between organising care around the general or the particular. But questions of what the “third sector” “is” and the stability of IAPT as “the mainstream” of psychotherapy in the UK are already moving these tectonic plates (McCabe, Wilson, and Macmillan 2018; Burkeman 2016). I have tried to capture some of this sense of constant movement and precarity in all three of the centres I spent my time in. In doing so, this ethnography reveals some of the painful tensions inherent in making and maintaining the “counter clinic”<sup>55</sup> within this particular configuration of mental health service provision.

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<sup>55</sup> The “counter clinic” refers back to the series of anthropological studies, introduced by Davis (2018), which I discuss in detail in Chapter 2 of this thesis.

The thesis set out to investigate the co-production of “place” and “need” in voluntary sector mental health care, in order to re-think and breath new life into the problem of “access.” Whilst the notion of co-production invites entirely non-linear and symmetrical thinking, I have divided my ethnographic chapters into two parts, starting with Place, followed by the second, on Need. The ordering of these parts has helped me to build an original argument, drawing on vitalist ideas of relationality and the milieu, as well as the afterlives of these ideas within medical anthropology and care studies, to understand how places are generative of certain forms of need, and in turn, can enable access to psychotherapeutic care. The legibility of *different kinds of need* reflected the global “turn” to migration as a matter of concern, as well as much more local organisational logics.

My approach has challenged standard public health approaches to the problem of mental health access, which is based on assumptions of pre-existing unmet need, as well as assumptions about healthcare contexts as inert background space in which this need is met. This raises a broader point about the relationship between place and need in healthcare more generally: that thinking about place as an external influence on individual ill health fails to acknowledge the dynamic relationship between people, their needs, the spaces of care they inhabit and make up, and (ultimately) the success or failure of care “working” on these needs. Re-thinking place and need in this dynamic way helps think about individual need, not as fixed to static identities, but to situations and moments in place (not *what* you are, but *where* you are). This re-thinking also opens up more honest conversations about how need comes to be known in particular ways. These ways of knowing often emerge from relations and responsibilities to a “mainstream,” that is itself constantly changing (“what is the NHS?”). They are therefore not fixed and should be open to critical analysis. Rather than evaluating success or failure to meet need and fill gaps within the third sector, we should be asking questions about how responsibilities, burdens, and failures of meeting need are (unequally) distributed across different care settings.

Following this line of thinking, I have made visible a paradox: in trying to “solve” the problem of access through mobilising voluntary care providers, the precarious nature of this care is produced *and reproduced*. In my analyses, precarity—a concept that encompasses the marginality of care providers and recipients, as well as the

sociomaterial instability of the sites of care—is not an *essential* feature of the voluntary sector, or the people who it is “for.” However, because of this dynamic relationship between people, needs, and places, this precarity is unequally distributed and felt acutely in the voluntary sector. In this chapter, I draw together themes that cut across the two parts of the thesis, making explicit my contributions: my use of ethnography and creative methods to foreground the socio-materiality of “access”; a series of interconnected arguments on the paradoxical relations between place, precarity and practices of inclusion in the third sector; and finally, my theoretical approach and how this has shaped my contribution to knowledge about mental health need. But first, a reminder of the arguments I have made and refer to throughout this concluding chapter.

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### **Overview of the arguments, in two parts**

Throughout this thesis, I have been arguing for a reformulation of the problem of access to mental health care, which moves away from seeing care providers as “solutions” to “unmet need.” Instead, I propose a conception of need as emergent and situated, taking the *places* of mental health care provision as the starting point for analysing issues of access to care. This opens up new problem spaces around practices of “doing need differently,” such as my finding that practices of inclusion in voluntary sector mental health care are *inherently precarious*. This overarching argument has emerged through a number of threads within my ethnography, which I have presented in two parts:

Part One describes how “place” came into view when the boundaries of services were crossed, and the capacities and continuity of their physical space was called into question. This process was particularly striking in the voluntary clinics that I carried out my research in because they never occupied a fixed or stable place, either materially or in the context of a wider landscape of mental health and social care. Further, I argue that this “coming into view” was tightly bound up with the spatial practices of access and inclusion: managing incoming referrals from a shrinking and overflowing mainstream in order to counter the risk of becoming a “dumping

ground” (Chapter 4), making and remaking the (non-mainstream) clinic as “sanctuary” (Chapter 5), and transition and place-making as an enactment of “precarious belonging,” particularly within current vernaculars around migrant mental health and extra-state services for “vulnerable migrants” (Chapter 6).

It was in this context that therapists and staff were engaged in constant work to survive and adapt to an ever-changing set of demands and relationship to “the mainstream.” I describe this as the labour it took to include people, who for various reasons did not have a secure or easily accessible place in mainstream mental health care. Because of an ethical commitment to inclusion, and a responsibility to provide psychotherapeutic care to people who often had nowhere else to go, this labour would challenge or breach the boundaries of care providers’ capacities. Precarity was a product of these on-going dynamics, rather than an essential feature of the voluntary sector.

Part Two picks up on what Part One had begun to reveal about the labour of inclusion, and the complicated, often fraught, relations these care providers had to the mainstream. It animates how need was enacted in these conditions, first by demonstrating how mainstream diagnoses of mental health need emerged as an “absent presence”: a product of relations between clients, therapists and the absent mainstream. The final chapter demonstrates how that “absence” was made into a presence of “something else,” through what I call *doing need differently*, within the logics of each care provider. In these data chapters, I am interested in the potential indeterminacy of need, particularly in these non-medical contexts, and the tension this created with notions of need as eligibility criteria for care.

I found that *doing need differently* created possibilities, but this came at a cost. To produce eligibility (and therefore access), care providers had to compromise their commitment to understanding need as limitless, dynamic, and indeterminate. They would make need *legible vis a vis* certain forms of difference within the milieu of the therapy centre. Crucially, these forms of difference were therefore highly contingent on the boundary work, precarious positioning, and (sometimes competing) interests that I argue characterises voluntary sector mental health care. Throughout Part Two of the thesis, I have sought to amplify the *ethical* commitment of my interlocutors to

create spaces and possibilities of indeterminacy when assessing mental health need, whilst exposing the trade offs and compromises they made in order to maintain this.

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### **“Surfacing” Place**

A key contribution of this thesis is a methodological one, in which I foreground place in my ethnography of access. This is an empirical approach but is also intrinsic to my conceptual work and development of theories of relationality, milieu, and material semiotics. From the start of this project I was interested in doors and the boundaries of the places that they provide access to (Simmel 1909/1994; Latour 1992; Latimer 2018), and became even more interested when I noticed how, the closer and more familiar I became with what lay beyond these boundaries, the more uneven and porous they seemed to become— at times almost disappearing from view.

In the first three chapters, I make use of a concept that I introduced in Chapter 3 (*Placing Need: A methodology*), conceptually extending Taylor’s (2005) work on “surfacing the body” to the notion of “surfacing place.” By this, I mean using my ethnography to understand how places *materialise* rather than treating them as static objects. To operationalise this concept, I developed a visual mapping technique, which I describe in detail in my methodology. Crucially, I treated the data that this mapping generated as images *in the making*, but also as one of many on-going practices and representations that produce place itself as *in the making*, building on perspectives in technoscience and non-representational theories of health and care (Barad 2003; Thrift 2004; Andrews 2018). This was useful when working with service users because it allowed them to revisit spatial and material “moments of access” in interviews. In this way, the data spoke to the idea that “surfacing” is also the practice of making surfaces of objects visible (Taylor 2005), but crucially, this “making visible” was a process of co-production with each person who had accessed or provided access to these spaces. “Making visible,” in this methodology, was not only the job of the researcher, but also the people whom I invited to do the “surfacing” and the “placing” I describe.

This method helped me discover that these “surfaces” (the doors, waiting rooms and other thresholds of therapy centres) often emerged as uneven and shifting: becoming more or less visible across different people’s experiences (including my own). Service users were often all too aware of the liminal spaces of waiting rooms and security buzzers, and (in one centre) the ambiguous no-man’s-land outside the main door; whilst for therapists, these surfaces could disappear from view over time. This was particularly salient in Chapter 6 when clients were “made migrant” by the spatial arrangements of the waiting room, whereas the sense of transition disappeared for staff as soon as the newness of their (recently relocated) centre subsided. The boundary between inside and outside came into view at moments of transition, newness and stuck-ness: the spatial conditions of “access”. For me, “surfacing” meant making place visible and then *keeping it in view*. Whilst the text of this thesis makes the methods and arguments appear linear, I was in fact constantly thinking about the material and spatial qualities of access and inclusion in tandem with my observations and analyses of mental health need and eligibility. *Placing need* was both a methodological and a conceptual contribution, established through the mapping work and the direction it pushed my analysis towards for the following chapters on the enactment of mental health need. This fed into my vitalist arguments about places *and* people as changing, unfinished entities: a refusal to fix my ethnographic gaze on a particular population or fixed notion of place or positioning in the care system.

### **The paradox of precarity**

I now turn to drawing together specific findings in the first three data chapters: how they contribute to understandings of place and states of precarity in the “third sector.” Intended to be read as separate stories on interconnected themes, these chapters constitute three versions of a paradox that I reveal about access, inclusion and precarity. I argue that in all three sites, the work of inclusion *reproduced precarity* (of service providers as well as users) as they managed their position of being “always different” and “always *almost* on the outside.” My methodological and analytical focus on the boundaries, thresholds and “surfaces” of these places, brings this paradox into focus. My arguments rest on the idea that practices of inclusion and

exclusion are inherently spatial and include the “boundary work” that staff and therapists engaged in to manage the incoming flow of clients as well as their distinctiveness from the mainstream. Inspired by and contributing to the field of material semiotics and care studies (Law 2003; Pols 2016; Moser 2017), I challenge clear distinctions between metaphors and materiality, particularly in relation to the spatial metaphors and material arrangements of “access.” This means that the “boundary work” I talk about is often in reference to symbolic work of maintaining social and professional boundaries *as well as* the material context of that work.

Chapter 4, “No Dumping” is about managing exteriority, or the threat of *being on the outside* of care infrastructure. The paradox here was that their (now impossible to uphold) “open door policies” created anxieties about becoming a “dumping ground,” as well as preoccupations with waste and “people out of place” (Douglas 2013; Ahmed 2000). The socio-material boundary work, which I describe as “tidying up,” constantly (re)enacted the organisation’s peripheral position in the health and social care system. The next chapter is all about the spatial politics of the Women’s Centre, this time focusing on the making and re-making of *interiority*: a place of sanctuary. I identified an on-going tension between the desire to preserve and maintain the therapeutic space and the need to adapt and extend boundaries in order to include excluded women, as well as simply to survive as an organisation. Paradoxically, practices of disaster and survival (along with the threat of encroachment, fragmentation and dilution of values) came to define “sanctuary” in this site. Chapter 6 on the relationship between precarity and place exploits a moment of transition (the moving of the centre) to understand themes of belonging and non-belonging amongst providers of the service as well as clients. Ultimately, I argue that precarity (and more specifically a sense of *precarious belonging*) is produced, not only by being *out of place* but by being *included* in certain places, at the margins of mental health care. In sum, these chapters point to a broader paradox in the way that inclusion and the “problem of access” is addressed in the everyday practice of third sector mental health care. The constant socio-material boundary work it takes to create and maintain places of safety, inclusion and care for people who may not “belong” elsewhere in the mental health system, can *reproduce* precarity, rather than solving problems of uncertainty, exclusion and instability.

In contrast to most of the social science literature on access to healthcare, which focuses on practices and policies of *exclusion*<sup>60</sup>, I have told a story of *inclusion*. Throughout my fieldwork, I often felt that, as an ethnographer, my job was to pinpoint the “unintended consequences” of practices and to “make visible” the exclusions and absences caused by inadequate care provision. But the more time I spent with people devoting their (voluntary or poorly paid) time to getting people through the doors of these three small services, and critiquing the mainstream for failing to do so, the less I felt that another critical voice “revealing” exclusion in these contexts would be useful. Despite the intense discussions around whom exactly these services were for and where their priorities lay, it was patently obvious that their overarching values revolved around getting people in, rather than keeping (certain) people out. What I did see, however, was an astounding amount of work, compromise, and *cost* (in values and time more than financial resources) involved in these practices of inclusion.

The boundary work I have described above was part of a broader concept I develop in the later chapters of the thesis on the *labour of inclusion*. This goes beyond the material and spatial boundaries of place and pertains to the production of need as eligibility criteria. What I seek to reiterate here, is that *this too* produces and reproduces the precarious nature of these forms of care and their accessibility. I therefore argue that inclusion itself warrants critical reflection, particularly in light of my earlier point that it matters *where* access takes place: when care provision is constantly *on the edge*, inclusion is troubled by risk, uncertainty, and compromise. I have maintained an ethnographic commitment to preserving the messiness of this story of inclusion *on the edge*. I take this forward in my discussion below on the tensions I observed in how need was enacted under these conditions.

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<sup>60</sup> As I have discussed in my literature review, research on healthcare access more generally is focused on “barriers and facilitators,” assuming that obstacles for the “hard to reach” cause exclusion. Critical social science literature on immigration and access to care also focuses on exclusory practices (Rousseau et al. 2008; McKeary and Newbold 2010; Arnold, Theede, and Gagnon 2014, for example), or illegality (Miklavcic 2011), humanitarian logics in France (Ticktin 2006; Ticktin 2011; Fassin 2012) or, like Goldade (2009), the way the “suffering body” has been used strategically, illustrating constraints on medical citizenship, whilst the work of inclusion tends to go unexplored.

## Different kinds of need, different kinds of place

In Part Two of this thesis, I focus on the enactment of *need* as eligibility criteria for psychotherapeutic care from these non-mainstream services. Specifically, I aimed to describe and analyse the processes, practices, discourses and spaces through which mental health “need” comes into being. The story that these two chapters tell lead on in various ways from the first three chapters; one thread being the spatial, practice-based and discursive production of *difference*, or more specifically, of *doing things differently* to a more standardised mainstream. Whilst methodologically I was not aiming to produce a comparative study of my field sites, ethnography invites constant comparisons between cases, as well as between the general and the particular (Yates-Doerr and Labuski 2015). Here, I want to turn my attention briefly to the differences *between* the organisations I worked with. Two surprisingly opposing themes emerged in Chapters 4 and 6: *dumping* and *belonging* (albeit a *precarious belonging*). Why were the organising themes in these chapters so different and how did they reflect the differences between sites?

Whilst both centres were places for people who were excluded from or turned away from mainstream services, often having “no where else to go,” Stepping Stones was constantly struggling against becoming a “dumping ground.” Bereavement was rapidly becoming a category of exclusion or “wastebasket category” (Lock 2013) for those without access to other forms of care. Staff at Culture in Mind also struggled to manage the demand for their service but I was constantly made aware that the heterogeneity of their staff and client group also held them together, as they shared various migration histories and forms of “cultural difference.” I watched as Stepping Stones’ open doors policies threatened to “sink them,” whilst Culture in Mind gained recognition from commissioners and funders and attracted the media, other third sector organisations, and academics with an interest in migration and culture in mental health.<sup>57</sup> This reflects the global “turn” to migration and mobility that I described in Chapter 2 and demonstrates the powerful interconnectedness of politics,

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<sup>57</sup> The Women’s Centre seemed to be well aware of this necessity to define whom the service was for (“whose sanctuary?”), and leaned increasingly towards organising the service around migrant communities and their needs. But these developments, as I describe in Chapter 6, came with their own specific politics of difference and recognition, that further complicate my comparative work between the centres.

public health and the academy. I came to understand that clearly demarcating difference helps to demarcate whose *interests* are at stake and whether these interests relate to *matters of concern* at larger scales (Latour 2004c; Moser 2008). Here however, I want to interrogate this comparison across sites with specific reference to my findings about the *legibility of need*.

In Chapters 7 and 8, I argue that differentness, and *doing things differently*, played a major role in making need *legible*. By this, I mean that need became operationalised as a knowable and negotiable entity *vis a vis* difference, and in particular, the environment (or milieu) in which difference is valued and cultivated. This contrasts sharply with the standards and universality that were seen to characterise mainstream systems of classifying mental health needs, even if we assume that universality must also be valued and *produced* in mainstream settings (Berg and Timmermans 1997, 2000). As service users came through the administrative system of referral, screening, assessment, allocation to a therapist, it was important to be able to articulate, and perhaps even more importantly, to *record* the kinds of needs that the person had and their resulting eligibility for psychotherapeutic care (making it *legible* even if it was not visible or entirely knowable). Chapter 7 speaks to the idea of being in opposition to the mainstream, where I tell stories of actors *making diagnoses absent* from their practice or their articulations of their own need. Samira, the young woman who had inherited an assortment of difficult and often contradictory assessments of need (deftly tossing them aside or bringing them into view when necessary) showed the risks and possibilities this offered her and her therapist. This chapter opens up an exploration of doing need differently that I address in the remainder of the thesis, following the “something else” that was made possible by this complex choreography of keeping the mainstream absent, yet always in sight.

The final chapter is where I develop the notion of the legibility of need more fully, in terms of the internal logics of *doing need differently*. I argue that need comes into being in relation to values and articulations of difference, within a given milieu. What I do not explicitly discuss in the ethnographic material in this chapter is the puzzling lack of articulations of need *from the perspective of the clients* at the centres (beyond the therapists’ worries about the absence of the “human in need” in their administrative processes). During the fieldwork, I was constantly perplexed by how little I was able

to glean from my careful questioning about what people felt their needs were and whether they felt they were understood in the needs assessments. Often, the distress they felt when they approached the centres was described elusively as “this,” accompanied by a gesture of hands about their chest or head; and when I spoke to them early on in their therapy, they would still be “finding out what was wrong” or “discovering new things each week.” Foregrounding place and the milieu in which need *emerged* helped me to make sense of this indeterminacy, next to (and spilling out of) the “boxes” that would be filled in in the administrative spaces I observed.

This focus on place also helped me to make sense of the comparison I made above between the troublesome position of being a service for “anyone,” and the clearly defined role of providing care for a client group recognised by their “cultural difference.”<sup>58</sup> The latter service, providing a therapeutic space specifically for ethnic and cultural minorities, was a more clearly demarcated and recognisable *kind of place*. Offering a new angle on how different social categories or “kinds” of person play into the know-ability of states of mental health (Béhague 2018; Hacking 1995), I showed how different kinds of need were made legible in, and *in relation to*, different kinds of place. If at times, it felt the population or “client group” of my study felt unclear or elusive, it is because these social categories were not my starting point and I wanted to maintain the shifting and at times ambiguous social criteria that determined whom these services were for. I was, however, interested in these categories and how they came into being in parallel to need: how they made different kinds of need legible. By *foregrounding* place, rather than seeing it simply as the “context” *in the background* of clinical assessments and containers for certain predefined “client groups,” I developed a novel and situated understanding of the way need was brought into being.

This interrogation of the practices, places, values and interests that enact “need” is becoming increasingly crucial to the analyses of medical anthropologists and sociologists looking at the health and social care system more broadly. At least within the UK context, the “emerging languages of need” that I have identified in mental

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<sup>58</sup> This finding builds on the work of Kirmayer (2011) on the “politics of recognition,” (Taylor and Gutmann 1992) with a slightly different focus; analysing the recognition of the care provider, and its logics and eligibility criteria over the individual or community.

health fields have been paralleled in the shift towards integrated systems of health and social care. “Need,” rather than disease or pathology, is what services are being designed to respond to, particularly in models of care provision that are trying to move the focus away from hospitals and “into the community”<sup>59</sup> (The King's Fund 2019). This is a direct result of the push to build a single system around health and social care, challenging the historical split between the two domains and the lack of social care which is “free at the point of access,” and currently based upon stringent assessments of needs (as well as means). The language of need seems to reach beyond standardised classifications of un-wellness or disability, particularly those needs which as seen to be specifically “social,” but the underlying assumption remains that they must be recognisable (or *legible* in the vocabulary I have been using) and ultimately “met,” even in projects that abandon notions of “cure.” And so the kinds of concerns I have been describing regarding how to recognise, make visible and manage upper and lower thresholds of “need” in non-medical terms, are by no means confined to voluntary sector mental health care. Medical anthropologists have a long line of established critique on narratives of medicalisation and diagnosis in the clinic, but we must develop new questions about the bureaucratic and socio-material arrangements of needs assessments in the increasingly blurred spaces between “the clinic” and “the community.”

### **Ongoing tensions between legibility and indeterminacy**

What were the *problems* associated with making need legible, and making people eligible for care, in this way? Throughout the thesis, I have been committed to charting everyday practices—particularly of therapists and staff, whom I was able to observe and talk to over many months—endeavouring to convey the internal logics and ethical motivations for each practice I observed. But as I draw these analyses together below, I want to state more clearly my own critical perspective on three implications of this enactment of need.

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<sup>59</sup> I use the phrase “into the community” deliberately to echo a phrase so familiar to mental health care, post-deinstitutionalisation (Milligan 2000).

The first problem with these practices of making need legible (which my ethnographic material vividly demonstrates) is that the legibility of these *different kinds of need* is not equal. In a cascade of various concerns, visibilities and interests, certain forms of difference gain traction and recognition, and in turn transform mental health need into inclusion criteria for specialised care. This is particularly powerful when those differences would otherwise represent *exclusion* criteria for mainstream mental health care. The cascade of concerns that I have been narrating is that of the growing global concern for vulnerable migrants, making cultural difference an increasingly visible and “interesting” aspect of alternative mental health service provision. My ethnographic data show that the opportunities this brought came at a cost: deploying this form of difference can render other needs *illegible* on an individual level (like in the case of Dayo in Chapter 6) or make “dumping grounds” of other sites that do not work with such recognisable social or cultural difference: the “wastebasket category” I mentioned above. These costs come hand in hand with the issue I discussed in my literature review about mobilising the vulnerable migrant category: of naturalising what Dahinden (2016, 7) has called the “migration container.”

Harking back to the first section of this chapter on the paradox of precarity, I found that this way of knowing need is also inherently precarious. Given the *material precarity* of these psychotherapeutic care providers, there is an uneasy reliance on these alternative spaces in which to bring this need into view. If any one of these services, or any specialised voluntary organisation like them, do indeed “sink,” and disappear entirely, there is no milieu in which these different kinds of need get negotiated; no ground on which differentness gets transformed into inclusion rather than exclusion criteria for care. The same goes for the precarity of matters of concern and the resulting legibility of need—in other words, the way I have described funding being dependent on shifting concerns and interests on much larger scales than local commissioning. Global concerns around migration and cultural difference manifested themselves in this way in my fieldwork. Whilst medical anthropologists working in mainstream contexts such as medical education worry about the reification and *entrenchment* of cultural difference and notions of “cultural competence” in monolithic knowledge systems (Metzl and Hansen 2014; Willen and Carpenter-Song 2013; Taylor 2016), I worry about *ephemerality* of this way of making need

legible in non-mainstream and marginal clinical settings: when the configuration of global (or national) concerns and interests change and are *not* reflected in alternative forms of care, will certain kinds of need become illegible and simply disappear from view?

The third critical point that emerged out of my observations on making need legible is a more fundamental issue: can and should human need *ever* be made legible, pinned down, and attached to particular forms of difference or pathology? I argue that this question is crucial to understanding the assessment and naming of mental health need, which my data suggests is a particularly shape-shifting, difficult to contain concept. This all points to the nagging theme of *indeterminacy* in care provision, which has cropped up at multiple points in this thesis. I touch upon this theme in my literature review, identifying ethnographic data in which “indeterminate norms” enable psychologists to improvise within state care (Matza 2018), and how the indeterminate nature of eligibility in humanitarian aid helps people evade norms of victimhood (Cabot 2013)<sup>60</sup>.

In my own ethnographic material, I too explore the potentialities and affordances of treating need as indeterminate, arguing that this is an ethical but *inherently precarious* position to take. In Chapters 7 and 8 I observe the wilful creation of spaces of indeterminacy when it came to assessing, articulating, and (more challengingly) recording mental health need. At times, this was done in order to avoid the risk of need being pinned to a diagnostic category, which could make clients ineligible for care, or discredit organisations because they can’t demonstrate “recovery.” At other times, the creation of spaces of indeterminacy opened up possibilities: in Chapter 8, I argue that “negotiating need” aimed to produce a more generous, inclusive mode of articulating need, embracing rather than trying to stamp out indeterminacies. The ability to treat need as indeterminate was a strength in these contexts, but this was painfully compromised by contractual requirements to make need legible. Here, my interlocutors were confronted with the on-going tension between legibility and indeterminacy: this, I interpret in terms of the difficult and always imperfect relationship between knowledge and life itself (Canguilhem 1952/2008).

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<sup>60</sup> I also noted how the potential indeterminacy of “need” in healthcare service provision has been identified, but only within the bioethics literature (Juth 2015; Herlitz 2017; Gustavsson 2014).

What might we learn more broadly from this case of mental health need, and the observation that creating spaces of indeterminacy provided possibilities for both service users and providers of psychotherapeutic care? Where else might commitments to treating need as “indeterminate” be a particular *strength* in the face of shifting responsibilities and modes of evaluation in healthcare? I often wondered as I carried out this research whether the will to create spaces of indeterminacy, and to avoid “pinning down” specific needs before the therapeutic process began, was specific to a) mental health care, (or even more specifically, psychodynamic psychotherapy) and b) to the scale of service delivery, which was so consistently described as “local” and “community based” in my fieldwork. I have been suggesting that there is something specifically indeterminate about the psychotherapeutic need that emerges through client-therapist relations. However, given that the theoretical work I draw on is not limited to the field of community mental health care (Greco 2004; Willen 2011; Herlitz 2017), my analysis of the value and utility of “indeterminate need” could play out beyond non-mainstream mental health or psychosocial care settings. As the NHS continues to fragment and the commissioning system encourages increasingly diverse healthcare providers, more spaces open up for ethnographic exploration of this question. Or, following the question of scale, we might ask how these ethnographic observations speak to “scaled up” practices in global mental health, where there is increasing awareness of the active use of “residual” or “unspecified” categories (First et al. 2018). This may revitalise broader, global debates on the classification of mental health and illness, which has for some time been in a state of profound uncertainty and flux (Pickersgill 2014; Ecks 2016).

These avenues for future work would build upon my analyses of the relationship between categories, need, and indeterminacy. In sum, I have identified and amplified the practices and views of my interlocutors that performed an important (often overlooked) ethics of inclusion. This involved their rejection of diagnostic categories, and other fixed “boxes,” which inevitably create exclusion. But I have also exposed the ways in which this commitment to indeterminacy—to allowing need to “spill out” of mainstream “boxes”—came at a cost. Maintaining this ethics of inclusion, of doing need differently, in practice, was laborious (and at times impossible) given the administrative demands to make need legible to funders and commissioners. The

implication of all this is that often, what is *valued* in mental health care (inclusion and indeterminacy) is simultaneously *constrained and threatened* by the logics of voluntary care and clinical commissioning. Following my lines of argument, it is possible to get out of this impasse: the challenge of doing (and knowing) need “differently” could be released from the specific constraints on the voluntary care sector and taken seriously throughout the healthcare system. Rather than a trade-off that must be negotiated within the logics and spaces of charity, we might think of the possibility of doing need differently as a broad ethical question, acknowledged and distributed throughout various spaces and places of care.

### **Reformulating the problem... “without ever imposing a solution”?**

When I started this project, I had recently returned to the UK, having worked for some years in or in collaboration with global non-governmental organisations that were also engaged in projects to improve access to healthcare. Though critical of many of the discourses around charity and humanitarianism, I was somewhat seduced by questions about whether alternative, community-based service providers were providing “solutions” to the much talked about problem of access to mental health services, particularly in the UK where the mainstream health infrastructure was so much better resourced than in humanitarian or low income settings. In abstract terms, if people were being excluded from services because they did not “fit” mainstream eligibility criteria or models of mental health care, rather than a complete lack of state care, then these alternatives might perform a very different and potentially exciting function. Later, after becoming immersed in the social lives of my field sites and the broader systems of care they were embedded in, talk of “innovation” and “impact” became painfully tangled with the struggling and fragmented landscape of care that Miles talked of in the scene I described above. My concerns turned to notions of fragmentation, brokenness, and even failure—a spectre that I have written about in my chapter on sanctuary, and later on, when the risks of “doing things differently” presented therapists with a near impossible task. What I have been arguing in this thesis is that thinking about access to psychotherapeutic care is much more productive when we turn our attention to the emergent and

constantly shifting nature of the problem. In doing so, I have challenged the very notion that the access problem can ever really be “solved,” or the “gaps filled” by alternative care providers.

By abandoning frameworks of isolated problems and solutions in our thinking about mental health care provision, I am not suggesting that problems do not exist, or that as care providers or researchers, we do not have to respond to them. Rather, I am saying that there is an inherent tension in the problem-solution way of thinking, because the *problem of access* is a moving target, and need is dynamic, always emerging in relation to care. Ethnography is useful for revealing these tensions, but perhaps more importantly, it opens up new ways of thinking about problems. However elusive notions of “mental health” and “need” might be, we can observe and sense the practices of inclusion and exclusion, of place-making, of encountering care, and all the other ethnographic material that I have been working with, to interrogate how they relate to and even *produce* these abstract concepts. By foregrounding *place*, and later on, broader notions of *the milieu* in my ethnography of access I have upended some of the assumptions that underlie much of the research and policies around issues of access to care. Rather than seeing need as a pre-existing entity or “gap” waiting to met or filled, I have described need as emergent and responsive to the sociomaterial arrangements of inclusion and exclusion at any given moment. Whether a “place for people with nowhere else to go,” a “sanctuary,” or a “space in between,” places have profound implications for the way that need and eligibility criteria for care are enacted.

How then, to respond to the tensions and paradoxes I have been describing, if not by providing a solution? We often hear anthropologists talking about revealing how something might be “done differently” as a result of their research, but of course this is what *I was shown* every day, through observing the practices of therapists and (at times) the clients they worked with. Critique of the mainstream was so hardwired into their practice of “doing need differently,” that it was sometimes hard to know what exactly the role of the visiting anthropologist should be at these sites. If I have “revealed” anything, it was the inherent precarity of these practices: “doing need differently” (but not *too* differently) was perilous, laborious and required constant sociomaterial boundary work in relation to an ever-present but ever-changing

“mainstream.” This fed into the making of precarious lives, and an uncertain sense of belonging amongst clients, even as these practices strived to produce inclusion and eligibility.

If, as I have been suggesting, precarity continues to be built in, and even traded upon, in our systems of mental health care, we must keep asking questions about the new problem spaces this opens up. Crucially, these questions should speak to care provision *across* these porous and fragmented systems, beyond what we currently call the voluntary sector. Problems of access and inclusion, as well as the possibilities of doing need differently, might then be distributed throughout spaces and places of care. To make this kind of thinking possible, we must attend to these spaces and places as generative and lively rather than merely inert absorbers of need.

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## Appendices

### **Appendix 1: Analytical questions to “ask” the visual maps**

#### **On the circumstances and interactions through which maps are produced:**

Important contextual information on the space and atmosphere in which map is produced (from field notes)

Are there patterns or specific non-verbal expressions that bear on the production of the map?

#### **On the production of maps:**

How do interactions with or interventions from me help produce the story of data?

How does the mapping unfold over time? Is it fast/slow? Does it afford reflection?

*See Gauntlett and Holzwarth on pace in creative methods (2006)*

What affective processes does the mapping exercise induce?

What does the quality of the hand-drawn image afford in terms of expression, fluidity, texture etc.?

*Ingold (2006) on lines*

#### **On what was being produced visually:**

To what extent does the map show a coherent, (temporally/spatially) linear narrative event? Are there disruptions?

*Literat (2013)*

What kind of metaphors/allegories does the mapping throw up? Is it obvious why?

*Gauntlett and Holzwarth (2006), Law and Singleton (2003) on allegory*

What does the map say about how objects ‘participated’ in the experiences of clients as they entered into the space?

*McGrath (2013) on objects in clinical spaces, Latour on the door and other “mundane objects” (1992)*

### **How maps speak to specific to research questions:**

How do maps engage with or illustrate boundaries/frontiers, inside/outside?

Are there particular forms of mental distress expressed through mapping?

How do people talk about personal embodied experiences of entering space—what does this say about what they are *becoming* through the experience?

Do participants feel a sense of their *own* precarity in/on the way to the space? How? Where?

What about precarious (or more safe/stable) elements *of the place*, and/or other places on their journey?

How ‘easy to place’ is the building and space within cultural templates of care settings?

