

CHAPTER 3: RESPONSIBILITIES AND CURRENT WELFARE DISCOURSES

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Introduction

Responsibilities and responsibilisation are among the core topics in current societal-political discussions on the transformation and new directions of Western welfare states, although the latter term is not necessarily used as such. They are also strongly present in the professional conversations and social policy literature concerning the expected roles of workers and clients in the welfare services. This chapter focuses on these discussions and the related scholarly work that form and analyse influential welfare discourses. These discourses, along with the governmentality literature, are potentially important when developing further a theoretical and empirical understanding of the issue of responsibilisation (see Chapter 2).

The welfare discourses introduced in this chapter are based on “keywords” in the sense that Ferguson (2007; see also Clarke *et al.* 2007: 27) understands them when he refers to Williams’ (1976) book *Keywords –A Vocabulary of Culture and Society*. Keywords, such as participation and empowerment, carry multiple meanings and can be used in contradictory ways in different settings. The meanings related to them are positive and hard to resist (Ferguson 2007: 337–338). Furthermore, they are used in justifying certain directions of change that are argued to be inevitable in the current welfare states and services. These features make keywords powerful and applicable both in policy level argumentation and in the everyday welfare practices. They can belong to the vocabulary of service user movements promoting full citizenship for everyone, of social and health care professionals describing how they support and help their clients or of managers and politicians

seeking new ways to organise services or cost savings. Also, researchers promote and reflect the keywords in making sense of the current welfare systems, welfare work and the realities of clients.

We will concentrate on such influential welfare discourses, and their underlying keywords, that (re)organise responsibilities between clients, workers, communities and the state. We do not make a thorough review of the roots or of the multiple meanings of the discourses. Instead, we will concentrate on how the discourses bring forward and problematise responsibilities between different stakeholders; particularly between clients and welfare workers in public services. We have grouped closely related keywords together so that altogether six keywords form three pairs of keywords and larger clusters of discourses. Each cluster has certain common features. The clusters are: 1) participation and empowerment discourses, 2) consumerism and personalisation discourses and 3) recovery and resilience discourses. Despite this grouping, the discourses are also interconnected and often referred to each other in the literature.

Participation and empowerment discourses

Participation

Participation is a valued premise in the democratic societies, and it implies “citizen power” (Arnstein 1969). It is linked closely to the idea of active citizenship. In the general sense, participation means “being involved or associated with others in some activity” (Anré 2012). “Being involved” might take many forms and occur in diverse contexts: from joining in spontaneous demonstrations to voting in public referendums, or from influencing personal service matters to taking part in collective user movements, or from doing voluntary work in different civil society arenas to helping old relatives or neighbours in their daily lives. Despite the various forms and contexts, participation generally means an aim to influence something and make a difference: to create more sustainable or equal societies; to influence plans and decisions concerning one’s own communities, neighbourhoods or services; or to increase one’s own well-being or that of other people in need. Daremo and Haglund (2008: 132) write that “participation can be explained using the concept of engagement, which means to take part, to be involved, to be included, to be accepted and to have access to necessary resources”. Having responsibility, been given responsibility and learning to take responsibility of one’s life is seen as vital in promoting participation (Daremo and Haglund 2008; Kvarnström *et al.* 2013).

Participation is regarded both as an intrinsic value in democratic societies and as a means in meeting and solving societal and individual challenges and problems. It is a principle hard to resist, because it is commonly understood as being absolutely good for everyone's well-being (Arnstein 1969: 216). It is expected that everyone in the end wants to participate and be active – and benefits from it.

In addition to the civil society context, participation is a strongly emphasised principle in social and health care services across Western societies (Beresford 2002; Kvarnström 2011; Kvarnström *et al.* 2012; Kvarnström *et al.* 2013; Matthies and Uggerhoej 2014; Raitakari *et al.* 2015). Client participation and service user involvement are intensively discussed and researched topics in social and health policies and services such as in social work, mental health and nursing. An expectation has arisen from a variety of directions that clients should have more active roles and power regarding their own well-being and services (Pilgrim and Waldron 1998; Drake *et al.* 2010). National policy documents and legislation have globally articulated the importance of client participation and service user involvement. Service users, as well as welfare and health professionals in various settings, have promoted the principle of client participation (Cahill 1996; Collins *et al.* 2007; Browne and Hemsley 2008; Kvarnström 2011, 8; Kvarnström *et al.* 2012). The service user movement has played a significant role in highlighting user involvement as a human rights issue (e.g. Bassman 1997; Cook and Jonikas 2002).

Client participation is commonly understood both in terms of individual or collective participation. At the individual level, it is considered important that service users are provided with information and that they are active in setting goals, defining support measures and making choices regarding their personal services. At the collective level, it is emphasised that as an important stakeholder group service users should be involved in the planning, providing, assessing and researching of services (Lammers and Happel 2003; Beresford 2002; Kvarnström 2011; Raitakari *et al.* 2015).

Participation is regarded as an important right: something that citizens and clients are entitled to. Professionals and welfare workers are seen as responsible for encouraging, enabling and supporting them to use this right. However, in many cases there are serious difficulties in realising participation in health and social services that can be related to the complex needs of clients, the attitudes of professionals, the dynamics of client-worker interaction, the ways services are designed and provided as well as to structural factors affecting the delivery and receiving of welfare services (Hickey and Kipping 1998; Tobin *et al.* 2002; Fischer and Neale 2008). It is also argued that

individuals should have the right not to become involved or to participate. Since service users have different interests and expectations about their possibilities and abilities to participate, there needs to be an option to choose to be non-active (Hickey and Kipping 1998; Lammers and Happell 2003: 387; Fischer and Neale 2008; Raitakari *et al.* 2015). Yet, these kinds of right-based arguments can be marginalised if participation is increasingly understood as everyone's responsibility. When emphasising the responsibility of citizens and clients to participate, it is not understood as an individual's free choice, but as a duty of citizenship and as a governmental technology to overcome exclusion and welfare dependency (Jayasuriya 2002; Paddison *et al.* 2008).

The concept of participation is related to the notion of empowerment that we introduce next. As Kvarnström *et al.* (2013: 288) put it: “a person can be empowered by enhancement of the person's participation, or have the need of being empowered to be able to participate” (see also Beresford 2002; 95–96; Adams 2008; Paddison *et al.* 2008).

Empowerment

Empowerment as a term is not a new keyword. It has been used and applied widely for example during the last four decades in community psychology and in social work (e.g. Rappaport 1987; Lee 2001; Lee and Hudson 2011). Adams (2008: xvi) defines empowerment as “the capacity of individuals, groups, and/or communities to take control of their circumstances, exercise power and achieve their own goals, and the process by which, individually and collectively, they are able to help themselves and others to maximize the quality of their lives”. Empowerment comprises thus both individual-level and community-level dimensions. According to Rappaport (1987: 121–122), it “conveys both a psychological sense of personal control or influence and a concern with actual social influence, political power and legal rights” and “is a process, a mechanism by which people, organizations, and communities gain mastery over their affairs”.

Empowerment has a dual meaning also in the sense that it refers both to the self-empowerment processes of individuals and communities and to the activities of various professionals aiming to encourage and support “powerless” people in the processes of becoming more powerful. Empower as a verb can be defined as making someone “stronger and more confident, especially in controlling their life and claiming their rights” (Oxford Dictionaries). In the “need” of empowerment are thus people or groups of people, often called marginalised people, excluded citizens or stigmatised groups, who are claimed to not have control and power in their own lives and communities. In the

empowering processes they are expected to gradually become enabled to master and improve their personal lives and living conditions and to get a voice and a capacity to resist inequalities produced by institutional practices and societal structures.

As participation, empowerment underlines active citizenship including (marginalised and excluded) the rights and abilities of individuals and communities to control their own lives and to help themselves. Paddison *et al.* (2008: 131) note that responsible participation “requires welfare recipients to engage ‘in the active management of their lives’ and this is portrayed as ‘empowerment’” (see also Jayasuriya 2002: 309). Self-help and self-management rhetoric is associated to the advanced liberal way of governing and to responsabilisation, for example, through the aims of creating self-governing citizens and communities and through strengthening the responsibilities of welfare clients for their own lives (see Chapter 2). Rose (2000: 334) sees empowerment as follows:

The beauty of empowerment is that it appears to reject the logics of patronizing dependency that infused earlier welfare modes of expertise. Subjects are to do work on themselves, not in the name of conformity, but to make them free (...) Autonomy is now represented in terms of personal power and the capacity to accept responsibility – not to blame others but to recognize your own collusion in that which prevents you from being yourself, and in doing so, overcome it and achieve responsible autonomy and personal power.

Not surprisingly the ambiguities of empowerment discourses have been criticised in social policy and social work literature (Pollack 2010). In an advanced liberal context welfare workers are charged with the responsibility of empowering clients by “reworking their subjectivities” to foster independent and self-sufficient citizens skilled at managing their own lives. Empowerment is thus argued to focus on individual factors, and the goal is a “cognitive restructuring” of the individual, rather than community-level work and structural or systematic changes. For example, Pollack (2010: 1268) claims that “social exclusion is reconfigured to be ‘a state of mind’ amendable to cognitive restructuring and empowerment” (see also Gray 2009: 451–453).

Conclusion

As important as criticism from the governmentality point of view is, participation and empowerment discourses cannot be understood solely as technologies of client self-responsibilisation at the margins of welfare services. The discourses also emphasise that to be able to govern one's life and to take responsibility of it are essential elements of well-being and self-determination. The possibilities and responsibilities to take part and be involved in communities and services are vital for a good quality of life. To be responsible and the one given responsibility are linked to a respected position in social relations and in society. A critical question is, do individuals have sufficient recourses, possibilities and support to become empowered and active? Empowerment requires empowering circumstances. Thus, the focus of the discourses is not solely on individual citizens' responsabilisation towards better life management and awareness of the duties in regard to other members of society (on responsibility projects); the focus is also on the disempowering policies, organisations, services and communities that needs to be transformed towards more empowering and inclusive environments. It is highlighted that citizens, clients and professionals should create partnerships to do this transformation work. Especially, the service user movement can be seen as an important political actor (way of participating) in aiming to create better services based on the wants and wishes of clients.

Consumerism and personalisation discourses

Consumerism

Whilst the participation and empowerment discourses discuss citizenship in a broad sense, which includes community-level actions, the discourses related to consumerism in public services looks more narrowly at citizens as individual choice-making service users in social and health care services. Clarke *et al.* (2007: 2, 16) describe the difference between the citizen as a political construct and as a consumer:

It is the consent of the citizen that empowers the state; while the state provides and secures the conditions that enable citizens to lead their lives. (...) In contrast, the consumer is located in economic relationships. S/he is engaged in economic transactions in the marketplace, exchanging money for commodified goods and services. (...) The shift from citizen to consumer individualises relationships to

collective services and depoliticizes ‘choice’ by subjecting the public domain to the logics of markets and management that constitute ‘choice’ in the private/market domain.

As with participation and empowerment, consumerism has been widely studied and discussed in the literature concerning human services (e.g. Clarke *et al.* 2007; Ferguson 2007; Fotaki 2009; Needham 2009; Greve 2009; Simmons *et al.* 2009). It has been demonstrated how the promotion of user choice that reflects consumerism has been dominant in welfare societies in recent decades.

In addition to the shift towards the logics of markets, consumerism is seeking another, related (ideological) shift: a move from a claimed welfare dependency and professional control to more active service user roles with associated rights and responsibilities. The overall idea is that clients should have more autonomy and control over their lives, including possibilities to make choices regarding the services they receive. Choices then concern where, how, when and by whom services are to be delivered (Le Grand 2005: 201; Raitakari and Juhila 2013). The claim is that the preferences of service users, instead of expert-defined needs, should be the first priority in providing services (Needham 2009: 79). In this frame, service users are defined as consumers, who as individual rational actors, know what they need, make decisions that maximise their preferences (Fotaki 2009: 88) and “express their views about services via complaints and feedback systems” (Barnes 2009: 231). Such approaches draw on rational choice theories (e.g. Le Grand 2007), which claim that people make decisions in their own interests by comparing the benefits and costs of existing choices (Greener 2007: 260). The duty of professionals for their part is to consult, inform and guide service users to make the best possible choices.

Similar to the discourses of participation and empowerment, the discourses of consumerism have been associated with advanced liberalism and neoliberalism in critical literature (e.g. Cossman 2013). Rose (2000; Miller and Rose 2008) connects consumerism to the core idea of responsabilisation which approaches citizens as “enterprising selves” who work for their own independency and well-being and along with increased possibilities make choices and thus also carry the risks of their individual choices (cf. Clarke 2005; Kemshall 2008; Teghtsoonian 2009). A serious criticism directed at these premises of consumerism is the extent to which service users in real life act as rational calculative actors. Rational choice making theories have been criticised for ignoring the fact that people invariably make choices in relation to other people, to certain embodied practices and institutional settings and to certain power relations that makes a rigid

consumerist approach inappropriate (Jayasuriya 2002: 310; Mol 2008; Hansen Löfstrand and Juhila 2012). Furthermore, clients with limited financial resources and complex needs at the margins of welfare services are usually not in a position to choose, for instance, which social or health organisation provides their services or if they should turn to private or public services. The clients also often lack information about complicated service systems and the options available to them. Bolzan and Gale (2002: 365) even claim that “a consumerist framework clearly establishes the role of professionals as gatekeepers to resources. How and when needs should be met is determined by these gatekeepers.”

In the end, consumerism cannot as Barnes (2009: 231) argues “encompass the depth and diversity of means through which people who use health and social care services seek to influence the social relations of welfare” (see also Bolzan and Gale 2002). Furthermore, it is not that much of a usable discourse in welfare services such as probation and prison work that are inherently based on the control and involuntariness of the clients.

Personalisation

Personalisation as a new keyword and a way of organising and providing public services only emerged and started gaining support in the late 2000s, starting in the UK (Glendinning *et al.* 2008; Leece and Leece 2011: 205–206; Needham 2011; Spicker 2013). It comprises many similar meanings as consumerism in regard to the responsibilities of clients and workers but extends the responsibilities and rights of clients further. Its roots are in the ideas of person-centred services.

Leadbeater’s (2004) pamphlet *Personalisation through participation*, as well as his other writings, is often cited when describing the core ideas of personalisation (e.g. Ferguson 2007; Needham 2011; Beresford 2014; Gardner 2014). According to Ferguson (2007: 393), these ideas include better customer friendliness, users having more to say how they navigate in service systems and how money targeted to their services is spent. Important differences when compared to consumerism are that in addition to regarding service users as choice making consumers, they are treated as co-producers and co-designers of services as well as solution inventors and decision makers in their own and their communities’ matters and problems (Leadbeater 2004; Ferguson 2007: 393; Glendinning *et al.* 2008). As Leadbeater (2004: 20) writes: “‘Deep’ personalisation would give users a far greater role – and also far greater responsibilities – for designing solutions from the ground up”. Needham (2011: 65) concludes that “personalization advocates have weaved

together a range of supportive discourses, encompassing the dignity and autonomy of the individual, the power of consumer choice and the failure of bureau-professional welfare states”.

The most well-known way to implement personalisation is probably through personal budgets targeted at citizens who are eligible for publicly funded support (Leece and Leece 2011: 206; Hamilton *et al.* 2016; Larsen *et al.* 2015). Personal budgets are seen to represent the high-level user autonomy and choice; users can design their budgets according to their wants and make decisions on how and where to purchase the needed support and services. Instead of offering similar services for everyone, personal budgets are argued to make personally tailored service packages possible. This calls for major shifts in the culture, roles and responsibilities of front line workers (Glendinning *et al.* 2008; Hitchen *et al.* 2015). Individually targeted budgets are also expected to produce savings in public service costs. It is shown in recent research that clients may gain autonomy, independency and recovery from personal budget arrangements that shift power to them, thus giving them a greater role in assessing their own needs and in making choices regarding services (e.g. Rabiee *et al.* 2009; Coyle 2011; Hitchen *et al.* 2015; Larsen *et al.* 2015).

However, personalisation has been a target of a similar kind of criticism as consumerism. Since the emphasis of personalisation is on individual service tailoring, it has claimed to be unsuccessful in engaging with structural issues, such as inequalities among people and inadequacies in social and health care services (Ferguson 2007: 395). The limited amount of available service options has been recognised as a major barrier in designing one’s own service package according to one’s own wants (Ferguson 2007: 396). In addition, users have to negotiate their service packages (based on care plans) with various social and health care professionals, who simultaneously also often assess their entitlement to various services. This kind of “personal assessment” conducted by professionals “implies that the professional, rather than the consumer, will make the decisions” (Spicker 2013: 1261). User choice can thus be restricted in personalised services; service users may exercise their freedom only within boundaries set by politicians and professionals. Sometimes the promotion of personal budgets might even decrease service options: for example current service producers often disappear from the “market” for being “old-fashioned” due to a changing commissioning policy. For example, Needham’s (2014) study shows how day centres for elderly and disabled people are seen as being unfit for a personalised service system and a tight fiscal context.

Despite the above described restrictions, personalisation discourses still expect clients to be active in planning their own services and to be responsible for making the right service choices. Beresford

(2014: 523) argues that in some cases personal budgets have meant the client “having to take on all the responsibilities and risks of running a personal budget without adequate information, back-up or support”. So, “doing it alone” is not necessarily an empowering solution. Significantly increasing individual responsibility for personal budget management can bring along stress and uncertainty and thus decrease the well-being of clients (Hamilton *et al.* 2016: 732). As Hitchen *et al.* (2015: 387) conclude “concerns remain about people’s ability to manage the additional responsibilities, especially when unwell”. Related to this, personalisation has been claimed to increase the need for brokerages especially in the complex care need cases that demand navigation between many health and social services. In these cases brokerage is named as a critical element in the success of the personalisation (Scourfield 2010). Brokers (special experts) supporting clients to manage personal budgets might take different (conflicting) roles such as becoming advocates of the choices of oppressed citizens, advisers of clients to make the right choices or gatekeepers of limited resources and unrealistic choices (Scourfield 2010; Leece and Leece 2011). Such worker roles as an adviser, controller and guardian are easily accompanied by deficient and stigmatised client categories; not being active, able and responsible enough to make independent service choices and manage the duties of a purchaser.

Conclusion

Even though the discourses of consumerism and personalisation have been criticised, the rights of citizens to make service choices and to have control in their lives are not questioned per se. Glendinning (2008: 459-461) writes that there are strong arguments for emphasising user choice. It is fundamental to achieving citizenship, social inclusion and independence. At best, user choice reduces power differences between care providers and receivers. The capacity to exercise choice and control over one’s life can also be an important recovery outcome itself. According to Hamilton *et al.* (2016: 722) “reclaiming control in terms of relatively small decisions may provide useful steps towards rebuilding an agentic sense of self”. These kinds of arguments are familiar in what Beresford (2002) calls a democratic service user involvement approach that is “often framed in a rights discourse” (Noorani 2013: 50). The democratic approach accomplished through collective user movement actions underlines people’s self-advocacy and participation in having more say in their own lives, services and society (Beresford 2002: 97). Choice offers opportunities to choose and plan one’s own services in a given service frame or to respond to official health and social care initiatives to evaluate and give feedback about available services. It also offers opportunities for citizens who have experiences of using social and health care services (experts-by-experience) to

voice their perspectives on service options and their contents and on more general issues of personal and social life (Barnes and Cotterel 2012: xx-xxi).

Recovery and resilience discourses

Recovery

Oxford dictionaries define recovery as “a return to a normal state of health, mind, or strength” (Oxford Dictionaries). According to this definition, recovery is thus a process during which something that has been lost is got back. This common sense understanding of recovery does not however reach all the variations that are connected to the recovery discourses in the current discussions. Recovery is a multi-dimensional keyword that comprises micro and macro level components (Jacobson and Curtis 2000; Barrett *et al.* 2010; Hunt and Stein 2012; Pilgrim and McCranie 2013). It is used to describe processes and characteristics of individuals tackling and living in difficult life situations. According to Jacobson and Greenley (2001: 482), “recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment, and connection – and external conditions that facilitate recovery – implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services”. Along with the recovery discourse a new message has emerged that people with severe conditions can have meaningful life and hope for the future, and they are entitled to the same human rights as all members of society (Brown *et al.* 2008: 24).

Recovery resonates and overlaps with the participation, empowerment, consumerism and personalisation discourses (e.g. Deegan 1996; Carpenter 2002: 90; Barrett *et al.* 2010; Brennaman and Lobo 2011; Hunt and Stein 2012). This can be read from Deegan’s (1996) personal account that resists the passive category of mental health client:

Those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have a voice and can learn to use it. We have the right to be heard and listened to. We can become self determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness. We can become experts in our own journey of recovery.

Davidson and Roe (2007) make a distinction between “recovery from” and “recovery in” mental illness, which are more widely applicable in social and health issues. They define “recovery from” as a process where the person recovers from problematic health conditions so that the symptoms ameliorate, and the person is more or less off medication and returns to a healthier state (Davidson and Roe 2007: 463). “Recovery in” “refers to the process of living one’s life, pursuing one’s personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse” (Davidson and Roe 2007: 464; see also Anthony 1993). It emphasises a person’s own agency, control over one’s own life and inclusion in communities, but it takes also into account the need for support and care. Pilgrim (2008: 297) describes “recovery in” as a community-orientated approach that “emphasizes supportive and personally tailored skills training to enable the patient to stay out of hospital and to maximize their ability to socially integrate”. Pilgrim (2008: 297) also adds the third recovery approach, “recovery from invalidation”, which is based on a social model (familiar from disability studies) and on a new social movement resisting expert-led diagnoses and treatment and coercive services. Within this approach recovery is defined as a release and a successful survival from stigma producing, deviant categorisations (see also Carpenter 2002, 89). These different approaches to recovery are in conflict with each other, yet they also help to depict the diversity of recovery and can be seen as complementary dimensions (Roberts and Wolfson 2004; Piat *et al.* 2009; Brennaman and Lobo 2011: 657).

Despite the above described multiple approaches of recovery, the discourse is often used in a way that constructs the individuals themselves as subjects of responsibility. It is depicted as gaining a new insight, strength and sense of self, of taking personal responsibility for one’s life and future (Deegan 1996; Carpenter 2002, 88–89; Roberts and Wolfson 2004; Pilgrim and McCranie 2013: 46–50). Roy and Buchanan (2016: 406, 409) write that the concept of recovery has “been hijacked and reconfigured by government” to hide “a wider government agenda of responsabilisation, the reduction of welfare budget and highly individuated conceptions of citizenship”. The concept has been associated with an advanced liberal way of governing especially from the point of view of self-responsibilisation. For instance, Scott and Wilson (2011), who have studied a recovery programme called *Wellness Recovery Action Planning* (WRAP) that is targeted at people with mental health problems, argue that the programme adopts neoliberal ideas of individual responsibility and reflexive subjectivity: it “constructs the prudent, responsible subject, who plans ahead, maintains control, is constantly engaged in self-surveillance and works incessantly to sustain a healthy lifestyle” (Scott and Wilson 2011: 41). An important skill to be developed is an ability to identify the risks that might cause unwell-being.

Another reading of the recovery discourses also recognises the roles and responsibilities of professionals, other citizens and societal structural factors in individual recovery processes (Carpenter 2002; Mancini *et al.* 2005; Roy and Buchanan 2016). Professionals and other people are expected to have “recovery competencies” and capabilities to foster recovery-friendly interaction and keep up hope in severe situations. In addition, it is their task to develop in cooperation with service users and experts by experience recovery-led working practices and services (e.g. Anthony 1993; Deegan 1996; Jacobson and Curtis 2000; Roberts and Wolfson 2004).

Critics of recovery discourses warn about being too optimistic for a speedy recovery and setting too high expectations on individuals because of the risks of disappointment, self-blame and “blaming the victims”. Recovery optimism may mean that service users are not given the right and acceptance to be ill and helpless (Roberts and Wolfson 2004; Piat *et al.* 2009: 205). Others have pointed out that when the recovery discourses – as in contemporary society – are drawn on more broadly, outside of a medical context and by others than doctors, for example in relation to societal problems such as homelessness, it might contribute to a medicalisation of the problem of homelessness (Lyon-Callo 2000; Hansen Löfstrand 2012). As concluded by Lyon-Callo (2000: 340–341), within the shelter industry, a medicalised discourse “produces everyday practices of self-disclosure and self-government as routine habits that are accepted as ‘common sense’”.

Resilience

Resilience can be defined as “the capacity to recover quickly from difficulties; toughness” (Oxford Dictionaries). Resilience and recovery are thus related concepts that attract a diverse range of professionals, educators, researchers and policy makers. The keyword of resilience is widely and increasingly used in relation to mental health problems, other illnesses and disabilities, but also among others related to traumas and psycho-social adversities, substance abuse, violence and child abuse, natural and man-made catastrophes, conflicts and warfare (Herrman *et al.* 2011; Walker and Cooper 2011; Bulley 2013; Simmons and Yoder 2013; Marriott *et al.* 2014; Kukihara *et al.* 2014; Sudmeier-Rieux 2014; Howell 2015). Essential themes in the literature are: What does it mean to be a resilient person? What enhances resilience? Who or what are responsible for it? (e.g. Herrman *et al.* 2011; Shastri 2013; Khanlou and Wray 2014).

Resilience, in a narrow meaning, can be considered as a personal trait, strength and ability that helps individuals to survive within difficult life situations. Like Herrman *et al.* (2011: 259) put it: “The central question is how some girls, boys, women, and men withstand adversity without developing negative physical or mental health outcomes” (see also Marriott *et al.* 2014: 18; Peer and Hillman 2014: 93). Resilience is typically connected to such characteristics as “self-efficacy, perseverance, good social skills and good communication skills, together with the aforementioned supportive networks” (Fougere *et al.* 2012: 707).

There are also more broad and interactive ways to conceptualise resilience that concentrate on protective and supportive forces at societal, cultural, community, family and individual levels (Herrman *et al.* 2011; Marriott *et al.* 2014; Khanlou and Wray 2014). Collectives and communities as wholes may also be seen as able to recover and be resilient or be responsible for promoting the well-being of individuals (Bulley 2013; Khanlou and Wray 2014; Muir and Strnadová 2014). Cultural resilience is related to the persistence of social-ecological systems and collective identities in the face of change and their ability to transform into more desirable states when required (Rotarangi and Stephenson 2014: 503; Folke 2006).

Welsh (2014) has constructed a comprehensive typology of resilience that comprises both narrow and wider definitions of the concept. He locates the origin of the concept on two parallel approaches, which he calls “socio-ecological” and “psycho-social” resilience. Both deal with the recovery capacities in the contexts of adverse events, disturbances and crises. Whilst the socio-ecological approach concentrates on larger environmental and human systems (Folke 2006), the latter one concentrates on individuals and their nearby communities (Welsh 2014: 16–17), and is thus applied more in the social and health care contexts. Psycho-social resilience is understood as “the ability to recover from trauma, and a capacity to persist or sustain health and psychological wellbeing in the face of continuing adversity” (Ungar *et al.* 2008; Zautra *et al.* 2010 cited in Welsh 2014: 17). Shastri’s (2013) description of how the concept is understood in psychiatry follows the same line:

(...) resilience stands for one's capacity to recover from extremes of trauma and stress. It is attributes of some people who manage to endure and recover fully, despite suffering significant traumatic conditions of extreme deprivation, serious threat, and major stress. Resilience in a person reflects a dynamic union of factors that encourages positive adaptation despite exposure to adverse life experiences.

In the resilience discourses responsibilities to promote and generate toughness are distributed between the state, citizens, service users and professionals very much in a similar way as in the recovery discourses. Although both concepts usually concentrate on personal survival, healing and growth, they simultaneously perceive the importance of social context and social support in surviving in life.

Critical reading of the resilience concept – and increasingly popular according to Howell (2015: 67) – associates it with governmentality and argues that it implies a new way to govern based on individual and community responsabilisation; communities, families and individual are made responsible for becoming resilient. For example, Welsh (2014: 19) writes about “the governmentalisation of resilience” by which he means that the resilient subjects are conceived as “responsible for transforming themselves in the face of a world of contingency whilst also increasing resistance to exogenous and internal shocks by limiting the potential of events to provoke change”. There is the danger that a shift towards the resilience discourses bypasses root causes and power issues related to risks, disadvantages and vulnerabilities in societies (Bulley 2013; Rogers 2013; MacKinnon *et al.* 2013: 262–263; Sudmeier-Rieux 2014). For Rogers (2013:322) “resilience is a form of governmentality that can have both positive and negative articulations”. Negative articulations are based on state-centric, top-down knowledge and practices that govern from a distance, whereas positive articulations foster citizen participation and empowerment.

Conclusion

The critical readings of the discourses of recovery and resilience as governmental techniques are valuable, but the meanings of these ambiguous keywords are much more complex. As Rogers (2013: 322) puts it, there is a “tension between positive and negative forms of resilience as governmentality”. The discourses carry emancipatory possibilities promoted for example by service user movements. Referring back to Davidson and Roe’s (2007) and Pilgrim’s (2008) definitions of different recovery approaches, “recovery in” and “recovery from invalidation” approaches emphasise the responsibilities of communities and societies (instead of recovering individuals) to accept differences among people and thus to deconstruct stigmatising categorisations and service practices. Similarly, resilience understood both as socio-ecological processes and psycho-social processes (Welsh 2014) helps to perceive recovery as interactional processes between individual and community responsibilities, and in this way it helps to resist the individualistic tones of

governmentalisation and responsabilisation (Bottrell 2009; Rogers 2013). Furthermore, as Bottrell (2009) suggests, resilience need not be defined solely as a positive adaptation to circumstances and personal coping with adversity: individual or collective resistance against social and cultural inequalities should also be recognised as enabling, protective and justified forms of resilience that shift the emphasis from individual to social responsibilities. Harper and Speed (2012: 23) summarise the need to redefine the recovery and resilience discourses: “we do not discount the need for recovery and resilience approaches to give a central importance to individual experience but it is absolutely vital that the conceptualization of individual experience is one that can be tied back to collective and structural experiences of distress, inequality and injustice”.

Conclusion and discussion

In this chapter we have described influential welfare discourses by focusing on how the responsibilities of different stakeholders in welfare services are dealt with and reflected in them. For a start we grouped the discourses along with the keywords they are based on into three clusters: 1) participation and empowerment discourses, 2) consumerism and personalisation discourses and 3) recovery and resilience discourses. All the discourses are interconnected, but the three clusters of discourses also differ from each other with their special emphases on the responsibilities between clients and welfare workers.

Participation and empowerment discourses operate primarily on a community and civil society level and approach clients in an active citizenship frame. This means that service users are expected to be both involved in planning their own services and to take part in such collective, service user actions that aim to develop better welfare services and better service practices. This kind of participation – having a voice – is a way to empowerment that results in increasing control of one’s own circumstances and quality of life. Consumerism and personalisation discourses are based on the market level logic. Instead of voice, the emphasis is on individual choice and entrepreneurial activity. Clients are understood as rational consumers, who are expected to have the capabilities to make the right, personal service choices among the available options, and to also carry the risks of the made choices. The third cluster of discourses that relies on the keywords of recovery and resilience refers mainly to the psycho-social level. This means that the focus is on personal healing pathways and abilities to survive illnesses and problems. Service users are treated as recovering individuals, who are actively, self-reflexively and with a resilient attitude engaging in their own healing.

Although operating at different levels, it is notable that all the discourses emphasise the personal responsibilities of clients; they have a responsibility to participate, to empower themselves, to make wise service choices and to promote their own recovery. This kind of individual responsabilisation matches well with the ideas of an advanced liberal way of governing and the related technologies of self-government. Furthermore, the discourses create responsibilities for workers to advance the responsabilisation of their clients by encouraging, supporting, advising and controlling. In this sense welfare workers can also be regarded as involved and responsabilized; the ones to be thanked or criticised for the successes and failures of clients. This responsabilisation of both clients and workers aims to end a claimed welfare dependency and to decrease professional power and paternalistic practices. The most successful welfare work manages to make itself unnecessary for clients, or at least it significantly decreases the need for support and care. In the cases of failures, the dependency of clients continues and is seen as chronic. This kind of responsabilisation embedded in the influential welfare discourses easily stigmatises, and it blames both the clients and workers tackling long-term conditions and difficulties that are an inevitable reality at the margins of welfare services.

Nevertheless, it would be oversimplifying to approach the discourses only in the light of individual responsabilisation and self-governmental technologies. In this chapter we have shown that the welfare discourses also include meanings that pay attention to structural issues and the social origins of individual adversities. Thus, the discourses conceptualise both individual and social responsibilities. This is most obvious in the participation and empowerment discourses whose cornerstone is an idea of the strengthening relationship between individual citizens and society. However, the recovery and resilience discourses that mostly concentrate on individual responsibilities and progress also contain structurally and socially oriented meanings (e.g. Deegan 1996; Jacobson 2001; Jacobson and Greenley 2001; Pilgrim and McCranie 2013). Communities, societies and service systems are understood as playing important roles in individual recovery processes and thus being responsible for these processes (cf. recovery from invalidation, Pilgrim 2008). Each discourse comprises critical arguments towards emphasising solely individual conduct; without empowering societal circumstances, social justice and equality, truly available service options or recovery facilitating communities, welfare services and financial recourses, individuals cannot be expected to become empowered citizens, wise consumers or recovered persons. So it is not reasonable or fair to put responsibilities and blame on individuals if the society does not first fulfil its responsibility to create and sustain inclusive and equal circumstances. It can be argued that

the welfare discourses support and justify the dual responsibility of welfare workers, which are to help individuals to overcome barriers and difficulties in life and to take part in changing social conditions. However, nowadays the welfare discourses are more and more on the service of clients' self-responsibilization and individualization of social problems. There is the risk that "the social" fades away and becomes unseen (Haynes 1998; Ferguson 2008; Hanssen *et al.* 2015; Kleppe *et al.* 2015).

In the welfare discourses responsibilities are always tied to rights. This is often forgotten in the critical analyses of the discourses. According to the discourses, individuals have not only responsibilities but also rights to participate, to make choices and to be treated as being capable to recover. In this sense the discourses construct clients as full citizens with accompanied rights. Furthermore, welfare workers are constructed as resources – to which clients are entitled to – in gaining full and active citizenship. Looking from the clients' rights perspective, workers have responsibilities to encourage clients to participate and be active at all levels of society, to coach them in choice making, to inform them about available options and to support them in their recovery processes.

The keywords that we have examined in this chapter – participation, empowerment, consumerism, personalisation, recovery and resilience – carry positive connotations in the current discussions concerning the transformation of Western welfare systems in a way that enables the citizens to have more active and powerful roles in societal and personal lives. They are thus hard to resist. However, the keywords have been problematised in the critical literature, especially from the advanced liberal point of view; some usages of the keywords can produce negative consequences such as discrimination and victim blaming that are to be resisted. Jayasuriya (2002) calls this dilemma of an empowering liberal aim yet one of disempowering results as a "paradox of liberal intent and illiberal outcomes".

In the critical governmentality literature influential welfare discourses are sometimes approached as "big policies" (Howell 2015: 68). Howell (2015: 68), who claims that resilience is increasingly associated to governmentality, writes that in this "big policies" approach "to some extent, subjects then are treated as 'dupes' (and not, for instance, engaged in multiple contestations, shaping, or even taking pleasure in governance)". Since the keywords carry multiple meanings and are used for various purposes, resistance can be accomplished in challenging and strengthening certain meanings of the keywords and downgrading others. If the keywords have been hijacked for certain

governance purposes, such as distributing responsibilities solely to clients for quick recovery, they can be hijacked back for the original professional purposes such as emphasising the role of social factors and social responsibilities in the well-being of citizens. It is also possible to create new meanings for the keywords or even invent new keywords if the current ones are too occupied with an advanced liberal understanding of responsabilisation. Whether and how these kinds of struggles and discourse shifts exist and whether certain “big policies” are dominant at grass-roots level welfare practices are matters of empirical investigation. In the next chapter we introduce methodological approaches and analytic concepts for this kind of empirical research.

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