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Who are the service users? Language, neo-liberalism and social constructions,

Introduction

In 2009, I published an article: 'What's in a name: "Client", patient', 'customer', 'consumer' 'expert by experience', 'service user' – What's next? (McLaughlin, 2009a)). As part of this article, I suggested 'the nature of the language we use is imbued with meaning and power, is dynamic and changing and that I would not be surprised for us to have developed an alternative term within the next ten years' (McLaughlin 2009a, p. 1115). Ten years have now passed; this chapter revisits the debate but also locates it within the current context of social work practice, arguing that our attention to language has never been more important than it is now – nor the context of neoliberalism, something that was sadly missing from the original article.

The current context

When the article was written it was 2008; Gordon Brown (Labour) was still Prime Minister, and we were still yet to fully understand or experience the impact of the international financial crisis. This crisis was triggered by the greed of bankers, which led to the breakdown in the subprime mortgage market in the US and the collapse of Lehman Brothers on 15 September 2008. This collapse sparked an international banking crisis and, as Dorling (2018, p. 3) notes, most 'governments in power in affluent countries were voted out of office at the subsequent general election'. Brown was later replaced by Cameron for the Conservatives in 2010, who had previously claimed at the Conservative Party Conference 2009 that 'we're all in this together, which is why we'll freeze public sector pay for all but the one million lowest paid public sector workers for one year to help protect jobs' (Cameron, 2009, n.p.).

In response to the financial crisis and the introduction of government-chosen policies on austerity (Jones, 2018), many governments chose to reduce 'public spending' and, in particular, the 'welfare bill'. Austerity, in this sense, is a situation in which people's living standards were reduced. From Cameron's statement, it could be considered everyone's living standards – those who were rich and those who were poor – would suffer equally because of the economic crisis. Surprisingly (Dorling, 2018), the bankers who had caused the financial crash escaped much blame, and many even took home larger salaries and bonuses than previously. As Dorling (2018) noted, both the UK and US, the two most unequal societies in the world, have become even more unequal since the crash, while increasing evidence has shown the social harm of inequality.

If increasing austerity alongside high and rising economic inequality had been a medical trial, that trial would have had to be halted on ethical grounds
(Dorling, 2018, p. 18)

This has resulted in those who are social work's major service user groups – the vulnerable, the poor, the disabled, the elderly and those whose lives are symbolised by precarity – all being targets for budget reductions, as were those who provided the services in the first place. In 2018, Professor Phillip Alston, the United Nations Special Rapporteur on Extreme Poverty and Human Rights, claimed in a highly critical report on the UK that:

British compassion for those who are suffering has been replaced by a punitive, mean spirited, and often callous approach apparently designed to instill discipline where it is least useful. To impose a rigid order on the lives of those least capable of coping with today's world, and elevating the goal of enforcing blind compliance over a genuine concern to improve the well-being of those at the lowest levels of British society. (Alston, 2018, p. 3)

Alongside the impact of government-chosen austerity, we have experienced an increased momentum and legitimacy of a neo-liberal orthodoxy worldwide whereby governments have been able to make public sector reductions by claiming that that they are a necessary requisite for getting out of the financial crisis. This has also been seen in an increasing emphasis upon individualism and a dismantling of the broader welfare safety net through benefit reductions and increasing eligibility criteria. This was particularly apparent in the government's desire to review payments for people with long-term conditions or disabilities and their commissioning of ATOS and Capita (private firms) to undertake the assessment for personal independence payments. Both of these companies' first responsibility is to their shareholders and thus needing to profit from their Department of Work and Pensions (DWP) contract by helping the DWP reduce the welfare bill. Far from being a success, the assessments by ATOS and Capita have been highly controversial, with an increase from 64% to 71% in successful appeals to social security tribunals between the last quarters of 2016 and 2017 (Disability Rights UK, 2018). Any other scheme with such a high degree of successful appeals would be seen as not fit for purpose, but only 5% of Atos and Capita reports were questioned by the DWP. Currently, there is no evidence that the DWP has made any commitment to change the medical assessment process.

Alongside this, there has been an 'othering' (Chauhan and Foster, 2013) of those in receipt of services as somehow different from the rest of us, as though they are non-beings because of these differences, thus making it possible for 'us' to treat the non-others as less human and reduce their rights to welfare. As Alston (2018, p. 18) noted:

The costs of austerity have fallen disproportionately upon the poor, women, racial and ethnic minorities, children, single parents and people with disabilities. The changes to taxes and benefits since 2010 have been highly regressive, and the policies have taken the highest toll on those least able to bear it.

At the same time, we have also seen reduced local authority funding leading the National Audit Office (2018) in the UK to claim that there has been a 49% reduction in funding in real terms

between 2010 and 2017; there is no sign that this direction of reducing budgets will be changed anytime soon. It would be no surprise if the current Brexit (non-)negotiations result in further cuts on welfare budgets and local authority spending in the UK.

Hayek (1944) identified the key tenets of neo-liberalism as, firstly, the supremacy of the market as the most effective means for the distribution of resources and liberty, and, secondly, the importance of liberty as the key political value. Liberty in this sense meant freedom from the state or other outside interference. Friedman (1962) famously argued that market mechanisms were so superior that they should be applied in most, if not all, areas of life. The mantra of individual choice and competition were deemed ways of improving education and health and social care. In England, we have seen schools removed from local education authority control with the introduction of academies and free schools; the growth of a private sector in health and the provision of adult residential care; and fostering services and residential children services by not just NGOs but also private, for-profit organisations whose primary responsibility is to their shareholders and for making profits. As Harris (2014, p. 8) has argued, 'neoliberalism's priority is the creation of conditions attractive to capitalist profitability in the global market'.

Alongside the growth in equality (Alston, 2018; Cummins, 2018), there has been a growing individualisation in attitudes, where the poor are believed to be poor because of personal failings and are therefore 'undeserving', thus permitting further reductions in services. This reduction in compassion (Alston, 2018) has provided fertile ground for increasing stigmatisation of those who are in receipt of social work and other welfare services. As Cummins (2019) argues, Goffman's (1963, p. 3) use of stigma is important here in signifying how stigma moves the stigmatised from 'a whole and usual person to a tainted, discounted one'. Wacquant (2008) also notes neo-liberalism is not merely an economic project but also a political one. This takes for granted that what is needed is a retrenchment of the welfare state and a reduction in the state's welfare net, to encourage its citizens to become economically active and avoid becoming a drain on the nation's resources. All of this personalising of individual ills neatly sidesteps the social and structural elements. In recent years, Bywaters (2018, 2015) has sought to show how poverty is linked to child protection, where, for example, a child living in one of the most deprived towns in England, Blackpool is eight times more likely to be in the care of the local authority than one in Richmond, one of the wealthiest areas.

Having provided a context against which patients, survivors, service users, clients, experts by experience or those with lived experience inhabit, it is time to consider how our language and labels impact upon our practice and open opportunities while also providing limitations on how human services construct these for those with whom they work. One other aspect the previous article ignored was the issue of interprofessional work, which is discussed next.

Interprofessional practice

McLaughlin (2013) noted that interprofessional practice has become so pervasive that it is rarely questioned and is often discussed as not only the best way of working but the only way. Lethard (2003 p. 5) eloquently described interprofessional working as a 'terminological quagmire' with terms like 'interprofessional collaboration', 'collaborative practice', 'multi-

disciplinary working', 'multi-professional working', 'interprofessional practice', 'transdisciplinary practice' and 'interprofessional working'. Banks (2010) notes that interprofessional practice is symbolised by two or more professionals working closely together, sharing common goals, and where there may be an interchangeability of roles. In the context of social work, the most common interprofessional partners include teachers, who refer to those whom they teach as pupils or students; doctors, psychiatrists, health visitors, district nurses and other health care professions who work with patients; the police, who have both victims and perpetrators of crimes; and lawyers, who have both defendants and those being prosecuted. This is not an exhaustive list, but it illustrates that different occupational groups refer to those to whom they provide a service by different names that indicate different types of relationships. A change in one profession's claims is likely to have a knock-on effect on the others. The words used by the different professions represent differing social constructions of the same person, reflecting different political, social and cultural contexts, each embedded with meaning from their own professional grouping.

It also highlights that professions like social work, paediatricians, psychiatrists, nurses, teachers, lawyers or the police are laying to a claim for jurisdictional boundaries and for the legitimate control of a particular area of practice; these are not necessarily self-evident claims but can be political ones.

It is assumed that by bringing different skill sets and expertise to work on the teacher's pupil/ health visitor's patient/lawyer's client/ policewoman's victim and social worker's service user will inevitably lead to better outcomes for the child and their family. There is a sense at that, at its simplest, 'the whole is greater than the sum of the parts'. Alongside this is an assumption that interprofessional practice represents a pooling of 'resources' and expertise beyond any single agency's ability to mobilise and deliver. This also potentially results in greater surveillance of service recipients. As Haggerty and Ericson (2007) observed, we are all subject to surveillance, but we are not surveilled in the same way or for the same purpose. An interprofessional team of a social worker, health visitor, nursery nurse, teacher and community police officer may monitor a single parent's child rearing, which may not be viewed as necessarily supportive by the single parent or her children. It cannot be assumed that all surveillance will be experienced as either benign or helpful (Banks, 2010).

Labelling social work

The labels we use to define the social work relationship – or should we say the service user relationship – create different pictures and ideas about the nature of this relationship and its construction. From the very beginning, it is important to recognise that you cannot have social workers without people for social workers to work with, on and/or for. Similarly, you cannot have 'service users', 'patients', 'clients', 'experts by experience' or 'people with lived experience' without first having service providers to provide services. There is a symbiotic relationship between the two. To have one, you need the other.

Secondly, the relationship is not based on binaries. One may be a social worker or a service user, but one can also have been a service user and is now a social worker or vice versa. In a

survey of children and family social workers in England, Johnson et al. (2019) found that one in seven (14%) of their total of 5,621 respondents mentioned that they had had personal experience of social services, which had been a factor in their motivation to become children and family social workers. Nine percent had had a positive personal experience and 5% a negative experience, with 1% indicating that they had experienced both. It is also possible to have been a social worker and then, following a mental health episode or physical injury, to become a service recipient. It is also quite possible to have moved between the two different positions on more than one occasion as the conditions causing the need for services has improved and then deteriorated again. It is also possible to need services for different reasons at different times. Lastly, it is also possible to be a social worker while in receipt of services. All these permutations are to remind us to never forget there is no essentialism about whether one is a service user or service provider; we can all move in and out at different times or even during the same time in our lives.

At this stage, it is important to consider the power of our labelling and the conceptualisations of those who are in receipt of human services.

The words we use to describe those who use our services are, at one level, metaphors that indicate how we conceive them. At another level such labels operate discursively, constructing both the relationship and attendant identities of people participating in the relationships, inducing very practical and material outcomes.
(McDonald, 2006, p. 115)

As McDonald argues, we should be both aware of the nuances of language and consider the messages we are delivering when we use it. The labels we use in social work act as signifiers in identifying and constructing identities and relationships, highlighting different issues and espousing differing assumptions about power and the nature of the professional relationship. Baron and Mitchell (2018) importantly identified how young people were identified in a Scottish secure unit as being so behaviourally difficult, they required a strict regime of control; however, when assessed for trauma, they were reconceived as in need of specialist support which, when delivered, resulted in better outcomes for the young people, staff and families. To examine this further, this chapter will consider various social constructions of this relationship, symbolised by the terms 'client', 'customer', 'expert by experience' and 'people with lived experience'. Other terms are also used to signify this relationship, including 'patient', 'consumer' 'survivor', 'activist' or 'citizen', some of which will also be touched upon in the discussion.

Client

In the late 1970s, when I qualified as a social worker, 'client' was the most common term used and was reflected in significant texts of the period. Mayer and Timms' (1970) *The Client Speaks* was the first book to privilege the perspective of those on the receiving end of social work practice. In 1975, Bailey and Brake (1975) published their classical text, *Radical Social Work*, which similarly used the term clients. While this is a term that is still internationally recognised and used, its origins come from the early 'almoners' who worked as medical social workers in

hospitals and who referred to those they worked with as 'patients' as well as 'clients'. The term 'client', while sounding quite neutral, is suggestive of a relationship much like that of the traditional 'doctor' and 'patient', whereby it can be argued that the good client was someone who was passive and acted on the professional's expert assessment. Power is located within the social worker, who is the one with the specialist knowledge and skills and is thus able to decide upon the best course of action to ameliorate the client's problems.

Within the British context, the election of Margaret Thatcher in 1979 was seen as a turning point at which the neo-liberal agenda could be seen to replace the welfare consensus. The introduction of the NHS and Community Care Act (1990) set to open the 'closed' market of adult social care to a mixed economy of welfare, redefining the role of social services from being a provider of social services to becoming a 'commissioner' or 'purchaser' of services. The commissioners and purchasers were expected to commission or purchase services less from the local authority and more from a mix of private and not-for-profit providers. At the same time, Thatcher was keen to reduce the power of professionals who were viewed as managing services too much for their own ends (McLaughlin, 2009b). Thatcher's solution was to introduce managerialism, which Adams (2002) notes put managers at the centre of organisations and imported practices from the private sector to ensure economy, efficiency and effectiveness of services.

As part of this organisational change, there was a push to relabel clients as 'customers' or 'consumers', following private sector norms. The social services recipient was recast as a 'customer' or 'consumer' who was able to choose between differing options from public or independent providers and to exit from a provider if they so wished (Harris, 1999). This empowering of human service recipients was more a case of smoke and mirrors. It was not really practical for someone facing a mental health assessment to suggest they wanted another GP or social worker from another local authority to do their assessment. The same could also be said for child protection investigations. While these changes could be argued as challenging the paternalism of the professionals, they could not be fully operationalised, although the seeds for increasing privatisation were clearly visible.

The defeat of the Tories at the 1997 election did not reverse this trajectory but rather gathered pace under Blair, the Labour leader's big idea captured by the term 'modernisation'. Modernisation (Cabinet Office, 1990; Department of Health, 1998) was viewed as the necessary process for updating public services to match the needs of modern-day consumers. It continued the attack on provider dominance while maintaining a focus on business solutions (Newman, 2000).

Denser Platt, when Chief Inspector for Social Services, summed up the government's approach in her annual report:

The present government is committed to reforming the public services. Its vision is of public services where the services are designed around the needs of the people who use

them, rooted in the values of the community. To deliver the agenda and to modernise the services we are asking the people who work in social services to work in new ways. (Platt, 2002, paras 1.4–1.5)

While this could be seen as potentially empowering for service users, Barnes and Mercer (2006) claimed that the move to greater use of scrutiny, inspection, audit and performance targets, far from increasing delegated authority, in fact reduced service user influence over service provision.

The service user

The acknowledgement of the importance of the service user mandate can be seen as an extension of the consumerist or customer tradition already discussed. As such, it can be viewed as a top-down approach (Ferguson, 2008). In opposition to this, it can also be traced to a more democratic tradition, or bottom-up, approach of promoting participation to ensure that services are fit for purpose.

The origins ('bottom up', emerging out of collective movements rather than 'top down') its aims (social change and social justice, rather than simply involvement in services), ideology (a social rather than an individual or bio-medical model of health and disability) and its methods (often involving collective action, rather than 'partnership' with its service providers. (Ferguson, 2008, p. 70)

The 'bottom-up' approach is therefore more radical than the 'top-down' approach and contains within it an inherent challenge to the status quo. In recent years, we have seen the development of user-led organisations, e.g. Shaping our Lives (www.shapingourlives.org.uk/), which is a national, independent, user-controlled organisation, with a network of 430+ user-led organisations, service users and disabled people advocating on behalf of service users, challenging service provider dominance and the status quo. Internationally, there is also PowerUs (<http://powerus.eu/about-us/introduction/>), an international organisation of social work academics and representatives from service user organisations seeking to develop 'methods of mutual learning in order to change social work practice to be more effective in supporting the empowerment of marginalized and discriminated groups in society' (PowerUs, n.d.).

In a research report by Shaping Our Lives (2017, p. 17), it is clear that there is still significant work to do, as a service user commented:

It is diminishing to realise how the service providers see service users. It is frustrating in the meetings to sense how little credence most of them actually give to service user viewpoints. If our view chimes with theirs they are positive and pleased with how things are going; if the service user perspectives challenge their views then they tend to offer platitudes and try to swiftly move the discussion on.

As the use of the term service user has become more prevalent, it is important to note that this is not without its critics. In social work, professionals can refer to 'service users' as a way of defining a group of people, e.g. those with mental health needs, people with disabilities, families in need of support and or crisis, children looked after and so on. What is important here is that this labelling of human beings is viewed through the prism of their status as service users and neglects all the other statuses that they may have which may be viewed as more positive. Thus, a service user may also be a school governor, a manager, magistrate, researcher, volunteer or grandmother, but what is viewed as the most significant by service providers is their status as being in receipt of services – a more inferior status than that of manager, magistrate, researcher, volunteer or grandmother. There is a danger that the use of the term 'service user' can be a way for professionals to restrict service user identity, suggesting a hierarchical relationship between those who commission and deliver services and those who are in receipt of them.

The use of the service user also neglects those who are either unable to access services or do not access services to which they are entitled. For example, Memon et al. (2016) found that for members of the Black and Minority Ethnic Community (BME), issues like cultural identity and stigma, financial factors, waiting lists, communication, cultural naivety, insensitivity and discrimination all resulted in their being less likely to access mental health services. Shaping Our Lives (n.d.) helpfully redefines service user in a more positive reframing, highlighting that it should be considered an 'active and positive term', in that it acknowledges we live in 'oppressive relationship with the state'. It is about 'entitlement to receive welfare services', resulting in some people considering service users as inferior as they have needed services for a long time, and being able to recognise that their shared experiences of using services gives members 'a strong voice to improve services'. How we define those we work with, serve, help, care for, advocate on behalf of or wish to empower is not simple or straightforward. It is thus not surprising that other terms have also been used. I would now like to move on and discuss 'experts by experience' and 'people with lived experience'.

Experts by experience

Banfield et al. (2006, p. 30) provide the rationale for experts by experience when they claim that:

Service users can be the best people to tell professionals what they want and need from any particular service, because it is intended for them and their knowledge of it is based on direct experience.

It could also be added that it is they who experience both the intended and unintended consequences of service delivery.

Experts by experience is also the term favoured by the Social Care Institute for Excellence (2019) and the Care Quality Commission (n.d.), which manage an 'experts by experience' programme that involves the public in health and social care inspections:

Experts by Experience are people who have personal experience of using or caring for someone who uses health, mental health and/or social care services that we regulate.(CQC, n.d.) It is important to first consider what an expert is. The Cambridge Dictionary (n.d.) defines it as a 'person with a high level of knowledge or skill relating to a particular subject or activity'. This definition clearly opens the way for anyone to claim they are an expert; there is no requirement for any specific educational training or professionally regulated activity (Johnson, 1972). Traditionally, expertise is viewed as the successful completion of a prescribed higher education training programme, followed by time spent learning in practice and potential promotion. While this is a common perception of an expert, it is by no means exclusive. As Scourfield (2010) has noted,

the adoption of the term 'expert' in the context of 'experts by experience' can be understood as a self-conscious and deliberate attempt to confront the power of the professions and democratise 'experience' in the domain of health and social care. It is used to equalise power differentials and to suggest that expertise by experience is every bit as valid as professional expertise.
(Scourfield, 2010, p. 1892)

Alongside this, we should note that in the UK, Statista (2019a) claims that 88% of households in the UK own a home computer, up from 13% in 1985. Statista (2019b) also claims that nearly 50% of all households worldwide have a computer at home, up from just over a quarter in 2006. This growth in access to computers at home has opened up the potential for most of us to use search engines like Google to self-diagnose our illnesses, compare evidence on services, contribute to service evaluations or link up with others who have similar concerns or wish to make changes to service delivery. Knowledge is no longer the sole preserve of the professional.

This claim to expertise is at one level a recognition that those on the receiving end of services have a right to be involved in the decisions that affect them. It also acknowledges that we cannot assume that professionals will always act in service users' best interests and that their privileged position should be open to question and challenge. It also provides opportunities for both positive and negative experiences to be identified. While answering some questions, it also creates others. How much experience does an expert by experience require in order to make this claim? Is it just one session with a professional, living with a disability for a month, a year, five years or a lifetime? The definition is also problematic in comparing and contrasting different experiences of 'experts by experience' who have the same needs but where one experiences the same service positively and one negatively. As McLaughlin, (2009a) asks, which one is right? Or are both right? Also, what about someone who wanted the service someone else received, believing it to be better suited for them? Can we take it for granted that they are right (or wrong)? 'Experts by experience', while helpfully drawing attention to the power imbalance between professionals and those they work with, highlights that the importance of service user voices and credibility of their experiences is imprecise and fails to differentiate between individuals who use services.

In recent years, we have also seen the emergence of 'people with lived experience', where the expert part of the label is no longer claimed. This has been evident in improving service through co-production (Curtice and Greig (n.d.) and in the commissioning of mental health services (Rethink Mental Illness, n.d.). It is interesting that the commissioning report also uses 'experts by experience', noting that these terms can often be conflated. 'People with lived experience' again highlights the importance of people on the receiving end of service providers but it fails to help us decide as to which person's experiences should be listened to. The terminology also fails to help us distinguish between conflicting experiences where one may be viewed as positive while someone in a similar situation views the same service as negative. Both references, however, argue for the importance of co-production and the facilitation of conversations between service recipients and service providers.

Conclusions

This chapter has highlighted that the way we speak about those in receipt of social services or any other human service must be considered not only in terms of the meaning of the word but also in relation to the context in which it is used. It also challenges us to consider the underpinning ideological nature of wider society, and in this case the neo-liberal hegemony. Keywords such as 'patient', 'client', 'customer', 'expert by experience' and 'service user' are integral to social work's discourses. Looking beneath the surface of these key terms offers us the opportunity to 'cultivate new habits of disruptive thinking' (Fritsch et al., 2016, p. 116), interrogating discourses that are often insufficiently questioned within mainstream social work (Chihota, 2017). Beckett (2003, p. 627) rightly warns us against 'naivete about the extent to which changing the names of things (using anti-oppressive language for example) can change the world itself'.

It is important to accept that we currently have no single term that is acceptable to all. However, whatever term is used, it needs to acknowledge that people who are identified as clients, customers, experts by experience or service users are more than the services they receive. They are not merely passive receptacles of professional assessment, whether in social work service delivery, education or research, but are also active actors in their own story. In the previous article (McLaughlin, 2009a), I suggested that we would find a better word to identify the relationship in the future, and maybe we will. However, what is probably more important is to recognise how many of the same terms are currently used without question, having become re-constructed within our current experience of austerity and neo-liberalism. In the end, maybe the best way forward is for social workers, educators, researchers and others to ask those with whom they are working to identify how they would like to be labelled and to be open to a discussion about the negative and positive implications of any particular term. Importantly, the 'professional', 'educator' or 'social researcher' should also reflect on the implications of their role identity and how it also impacts upon the encounter and its implications for those with whom they work.

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