Narratives of societal vulnerability. An insider's critical reflection of social policy practice

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Abstract: Despite social policies aiming to realize an inclusive society, social exclusion of vulnerable groups happens. We analyse the experiences of vulnerable persons with the implementation of social policies. The analysis of in-depth interviews highlights vulnerable persons' interactions with social policy practitioners. This insider's perspective provides insight in how they experience access to social rights. Respondents report feelings of intensified vulnerability, a confrontation with too much bureaucracy, and a range of insufficiencies in practitioners' approaches. The bureaucratic contexts often fail to meet persons needs due to protocols and budget restrictions. To implement a more individualized approach, practitioners need discretionary space in which they can apply moral-ethical considerations and be responsive to personal requests. Based on the acknowledgment of the insider's perspective and addressing the shortcomings of the social policy practice, practitioners can pave the way for more social justice.

Keywords: Accessibility of social rights, social inclusion, social policy practice, societal vulnerability, vulnerable persons

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Introduction

Social participation and self-reliance are themes that enjoy high priority within the policy of the European Union (EU). The aim of this EU strategy is to contribute to the achievement of smart, sustainable, and inclusive growth (Gros and Roth, 2012), which implies that an inclusive society will enable both economic welfare and personal well-being (Rutenfrans-Stupar, 2019).
In line with this EU policy the Dutch government has been transforming its traditional welfare state into a so-called 'participation society', in which social participation and self-reliance are strongly promoted (Rijksoverheid, 2013). This implies that citizens take responsibility for their own lives, take care of themselves, support each other, and play an active role in society.

The transformation towards a 'participation society' was primarily motivated by budget cuts (Putters, 2013; Rijksoverheid 2013; Verschoor, 2015). The social security system underlying the traditional welfare state would eventually become financially untenable (Rijksoverheid, 2013; Bruggeman et al., 2018). By promoting social participation and self-reliance the Dutch government wanted to clarify that appealing for government support should no longer be automatic (Bredewold et al., 2018; Bruggeman et al., 2018). Only when a person has no other resources at hand, such as care provided by a social network or money of their own, does appealing to government aid become an option (Van Houten et al., 2008; Rijksoverheid, 2013; Bruggeman et al., 2018).

Social participation and self-reliance are the social norms that every citizen should meet. In Dutch social policy practice, those who do not or insufficiently meet this standard are labelled 'vulnerable people' (Winsemius, 2011; Eugster et al., 2011, 2017; Putters, 2018). According to literature, vulnerable people are persons who do not enjoy full physical, psychological and social well-being (Jehoel-Gijsbers, 2004; Metz, 2009; Provinciale Raad voor de Volksgezondheid en Maatschappelijke Zorg in Noord-Brabant [PRVMZ], 2010; Bruggeman et al., 2018). 'Vulnerable people' and 'vulnerability,' can be understood as socio-political concepts in Dutch society. This is an outsider's perspective. The perspective of social policy and by consequence of social policy implementers. These socio-political concepts allow outsiders to label people as 'vulnerable' and relegate people to the group of vulnerable people. Framing them as such can be considered an indication of social exclusion, and thus social injustice.

In a previous article we explored the concept of vulnerability from the perception of allegedly vulnerable persons themselves. How did they perceive being labelled 'vulnerable'? (Numans, Van Regenmortel, Schalk & Boog, 2020). Based on our empirical data we found that perceived vulnerability increases when interacting with other, non-vulnerable people in society. Remarkably, especially in the interaction with social policy implementers such as (mental) health care professionals, social service providers and social workers who operate in the institutional life domain,

respondents expressed experiences of even more increased vulnerability. Underlying this perceived increased vulnerability lies a relationship of dependence, which is more at play in the interaction with representatives of the institutional life domain than in the interaction with others - non-vulnerable people - in other life domains, such as family life, leisure activity, volunteer work or education (Numans, Van Regenmortel, Schalk & Boog, 2020).

Although the role of social policy implementers (referred to as 'practitioners') is to help and support vulnerable people, giving them access to social benefits and services, contributing to their well-being and thereby steering them towards social participation and self-reliance, the opposite seems to be case. Social participation and self-reliance are hindered.

In this article we focus on the experiences of so called 'vulnerable persons' when interacting with practitioners in the institutional life domain. We explore the negative experiences with practitioners voiced by these insiders.

The current situation

Although the intentions of Dutch social policy and its implementation are positive, they do not have the desired effects in society and the everyday lives of vulnerable persons. The opposite is observed. Firstly, vulnerability remains in society and the number of persons labelled 'vulnerable' is even growing (Sociaal & Cultureel Planbureau/Centraal Bureau voor de Statistiek [SCP/CBS], 2014; Coalitie Erbij, 2015; Bijl et al., 2015, 2017; Putters, 2018; Centraal Bureau voor de Statistiek [CBS], 2019; Wolf, 2019). Apparently, the 'participation society' sets high standards for people's self-reliance and participation, which many – especially vulnerable persons - cannot meet (Wetenschappelijke Raad voor het Regeringsbeleid [WRR], 2017). Despite a social policy aimed at realizing an inclusive society, social exclusion results. Secondly, government expenses for care and support, social security and healthcare costs are rising instead of reducing (Rijksinstituut voor Volksgezondheid en Milieu, 2018; Steiner, 2019; Centraal Bureau voor de Statistiek [CBS], 2021). This raises the question: Where does it go wrong?

An insider's perspective related to experiences when confronted with practitioners can yield directions for answering this question. This perspective hardly receives attention in Dutch social policy and literature. Social policy and theory usually are concerned *about* people from vulnerable populations, rather than *with* these people (Abma et al., 2009, 2011; Van Regenmortel et al., 2013; Siesling and Garretsen, 2014). Why are people from vulnerable populations perceiving increased vulnerability when appealing for government support to participate in society and be self-reliant? In this paper, we present our findings based on an in-depth bottom-up approach, to explore the views expressed by vulnerable persons regarding the perceived growth

of vulnerability due to practitioners. With this we aim to further our insight into directions in which social policy practice could improve.

Methods

Design

The empirical data presented in this article stems from a study (2017 – 2019) in which the concept of vulnerability as perceived by vulnerable persons takes central place. The study was conducted in a medium sized city in the Netherlands. The study used a naturalistic inquiry, which aims to understand the particularities of a phenomenon in its natural setting and the perception of those involved (Lincoln and Guba, 1985). The complexity of the concept of vulnerability, together with the richness of data that have been put forward by insiders, enabled us to focus on various aspects and bring these to the fore in a series of articles. These aspects concern the insiders' perception of vulnerability itself, the actors and factors that play a role in perceived vulnerability, and how vulnerability can be reduced or prevented?

Data collection

Clarifying the perception of respondents, requires a conscious and linguistic construction of meaning. Therefore, a dialogue between researcher and respondent is needed (Tromp, 2004; Baarda et al., 2005). We chose in-depth interviews which provide space for respondents' narratives and allow for searching specific experiences and feelings of respondents which are important to the perception of vulnerability (Abma and Widdershoven, 2005).
The interviews were prepared and conducted by a mixed research team, consisting of the first author (principal researcher), the second author, and eight co-researchers: four persons from vulnerable populations and four professional social workers. All were familiar with the insider's perspective on knowledge of vulnerability. All co-researchers conducted interviews with persons from vulnerable populations under supervision of the first and second authors. To conduct the in-depth interviews, we used the Interview Guide Approach (Patton, 1987). To ensure reliability and validity, all co-researchers were prepared for conducting in-depth interviews through theoretical and practical (interview) training and reflexive sessions.
The in-depth interviews consisted of two interviews with each respondent. Interview 1 focused on the theme 'Me & vulnerability,' to gain a good understanding of the perceived vulnerability at the individual (personal) level. In interview 2, the theme 'Others and process' took central position, focussing on the actors and factors that

play a role in the perceived origin, aggravation, reduction and continuation of vulnerability. Interview 2 also covered the interactional level in all life domains, aiming at gaining insight in potentialities leading to improvement.
In total 33 interviews were conducted: 2 interviews with 13 respondents (interviews 1 & 2), 3 interviews with 2 respondents (interviews 1 & 2), and 1 interview with 1 respondent (interview 1). Deviations from the standard 2 interview procedure were made with the consent of the respondent.

Respondents

The sample size was limited to 16 respondents and based on purposive sampling (Marshall, 1996; Smaling, 2014, with reference to Patton, 1990, pp. 182-183; 2002, pp. 243-244). The following selection criteria were used: (1) Eligible respondents met the current description of 'vulnerable persons' as indicated in the Introduction of this article; (2) They were at least 23 years old (from the point of view of (assumed) 'wisdom of life' and/or life experience and reflective capacity; (3) They understood the Dutch language and were able to express themselves verbally; (4) They perceived themselves as vulnerable. Diversity in age distribution and gender were also considered.

The 16 respondents ranged from 31 to 75 years of age (mean 49) and included 7 men and 9 women. Of the 16 respondents, 8 respondents suffered from physical health or sensory problems, from progressive muscle disease, multiple sclerosis (MS), cerebral palsy (CP), blindness, and heart and lung disease. The other 8 respondents suffered from mental illness such as personality disorder, borderline disorder, depression, panic disorder, and hypersensitivity. Three respondents had an income from employment; the other 13 respondents received social benefits. The respondents decided where and when the interviews took place. Most took place in the respondents' own homes. The interviews lasted approximately 2 hours (varying between 61 and 178 min).

Ethics

Interviews were recorded and transcribed verbatim with respondents' permission. All persons participating in the study gave written informed consent for each interview. In providing consent, respondents were given the option to withdraw their consent at any time. The research protocol was approved by an institutional ethics review board.

Analysis

Analysis was guided by Thematic Analysis, in which patterns or themes within qualitative data are identified systematically (Braun and Clarke, 2006; Guest et al., 2012; Maguire and Delahunt, 2017). A characteristic of Thematic Analysis is that it relates to both phenomenology and grounded theory (Charmaz, 2006; Guest et al., 2012), two approaches that formed the core of the study. In our analysis multiple (co)researchers were involved (check-coding): the first and second authors, and a co-researcher with a scientific background and familiar with data-analysis. All transcripts were coded by these three researchers.

Our analysis was based on the collected data which in turn were streamlined by the topic list, aimed at answering the research question. We started our analysis by using a combination of interpretation and open coding, assisted by ATLAS.ti (version 7 for Windows). As a starting point we discussed some preliminary ideas about the codes and developed some initial codes as point of departure for the coding based on reading some transcripts. We did not have pre-set codes or a pre-existing model or frame in which we tried to fit the data. On the contrary, our analysis was driven by the data itself. We developed and modified the codes as we worked through the coding process by regularly comparing our codes. In case of inconsistencies, doubt and/or disagreement in co-coding, the coders discussed till consensus was reached about a code. This process led to a final code-tree. The main themes on the code-tree were vulnerability as experienced by participants, the process of vulnerability over time, the perception of type of contacts in relation to perceived vulnerability, and suggestions for improvement.

The next step in our analysis consisted of moving back and forth between identifying, reviewing and defining themes. Coded segments of coherent data under each (sub)code were grouped to discern patterns and define the final themes. In this phase one new theme emerged. Looking for patterns in perceived vulnerability at the interactional level and the different life domains in which respondents operate, to our surprise we found a considerable number of expressed criticisms concerning the interaction with practitioners in the institutional life domain. This was not a topic during the in-depth interviews.

As described above, during the second in-depth interviews we explored who and what plays a role in the various life domains and what this meant for the perception of vulnerability. The objective was to retrieve suggestions for improvement to reduce perceived vulnerability from these data. Although we did not explicitly ask for criticisms, the data revealed that apparently respondents felt an urgent need to express these. Noticeably less criticism was voiced about other life domains in which respondents interact with people.

Given the richness of the expressed criticisms, we were unwilling to ignore these, precisely because of the double objective of the study: 'to prove' and 'to improve'. Our interest was not only 'to prove,' to develop both practically relevant and academically

founded knowledge based on the silenced voices of 'vulnerable people,' but also 'to improve'. That is to potentially contribute to improvement in practices or in the living situations of 'vulnerable persons (Fals-Borda and Rahmann, 1991; VanderPlaat, 1999; Reason and Bradbury, 2001; Abma and Widdershoven, 2006; Huntjes et al., 2011; Van Regenmortel et al., 2013, 2016; Migchelbrink, 2016).

Guided by the Grounded Theory Research Approach (Glaser and Strauss, 1967; Charmaz, 2006), we could distil unexpected, valuable information. The reflexivity journal that we created and maintained from the outset was helpful in the phase of data-analysis. In this journal we documented our steps, our (preliminary) impressions, and reflections on potential findings. This was useful for reflecting on emergent patterns, codes and themes (Saldana, 2009).

Quality procedures

As a quality procedure we performed member checks on the results of the first analysis of data with three stakeholder groups: the co-researchers, an advisory board group and the respondents.

At various times during the stage of data analysis, we briefed the co-researchers on preliminary interpretations and findings. At one time we performed a member check with an advisory board group, consisting of representatives of social policy practice. All input was taken into account and, when possible, processed. This is in line with Lincoln and Guba (1985) who consider member checking as a process that occurs continuously during the research project, and comprises the testing of data, analytic categories, interpretations and conclusions with members of the stakeholder group(s). It contributes to the reliability and validity of the researchers' work (Lincoln and Guba, 1985).

Since the respondents' criticisms emerged from the data so unexpectedly, we decided to also do a member check with our respondents to check whether they recognized their voices in our preliminary findings. Based on renewed contact with respondents who provided us with written informed consent (12 of 16), 4 respondents (hereafter named 'participants') eventually took part in the member check. The member check consisted of three focus group sessions, each lasting approximately 3 hours. The other respondents withdrew for various reasons, such as health issues that hindered participation, being disinterested, and feeling uncomfortable in a group setting.

Findings

In this section we first present the outcomes of analysis of spontaneously expressed critical notes of our respondents with respect to social policy practice. A member check on these preliminary findings (see Table 1) led to a final version, presented at the end of this section (see Table 2). While using relevant theory, we reflect on our findings and present this in our discussion. Both literature as well as reflection intend to provide further insight into the meaning of respondents' expressed criticisms and to inform the knowledge needed to contribute to the improvement of social policy practice.

An insider's perspective on social policy practice

Clusters of organisations to deal with

Respondents' criticisms concerned four clusters of organisations, which are: (1) 'Social services', understood as (semi-) government institutions that work in the field of social security, such as social benefit agencies, social services, income providers, reintegration and housing agencies; (2) 'Welfare organisations', institutions that work in the field of welfare, such as community centres, social work, and voluntary work; (3) 'Physical care organisations', institutions that work in the field of the assessment of care needs (so-called 'indications'), the provision of medical aids, and the provision of (physical) care (doctors, care providers); (4) 'Mental health care organisations', institutions that work in the field of mental assistance, for example sheltered housing, homeless shelters, assisted living, and mental health care.

All respondents deal to a certain extent with these clusters of organisations to be able to live their lives. They are dependent on these organisations due to their (physical or mental) disabilities or illnesses, often accompanied by a lack of financial means. No differences were found in the criticisms with respect to a specific type of organisation, nor regarding the type of vulnerability respondents faced. On the contrary, there was clear evidence of similarities in respondents' criticisms when confronted with any cluster of professional help and support.

Preliminary findings of criticisms

In looking for communalities we grouped our respondents' quotes of expressed criticisms into nine main categories. Out of these, five main categories required more fine-tuning to capture the quotes more precisely. Therefore, we divided these main categories into subcategories. The respondents' quotes we covered in scopes of criticism. In table 1 we present our preliminary main categories, subcategories, and scopes of criticism.

Table 1
Preliminary findings of expressed criticisms on social policy practice

	Main category & subcategories	Scope of criticism
1	Lack of self-determination	They determine for you and are in charge of you. They know what is right for you. They patronize.
2	Lack of a positive approach	No personal customization in what is possible. Not looking at what you can do, at qualities, despite limitations; only looking at impossibilities.
3	Lack of social embedding 3.1 Target group / supply oriented 3.2 Alienation from society	Few alternatives in the range of activities for target groups. You belong to the world of the disabled or psychiatry, leading to social exclusion. Everything is done for you, not being stimulated into making contacts, and being inhibited in the process towards independency.
4	Lack of a personal approach 4.1 No approachable helper, anonymity 4.2 Rules, protocols and standards driven instead of personal customization 4.3 Client file-driven instead of client-driven	An untraceable official. Anonymous telephone numbers and letters, no longer a person at the desk, being sent from pillar to post (maze), and unclear who makes decisions. Indications are based on standards and assumptions, they follow the book, you have to conform to protocols. They (continue to) use the report or file as a starting point.
5	Bureaucracy 5.1 High burden of proof 5.2 Distrust 5.3 Slowness, laboriousness 5.4 Penalising 5.5 Demotivating 5.6 Accusatory	There are many rules, you have to fill in all kinds of papers to get what you are entitled to. Disbelief. You are seen as a 'fraud' and they assume that you are cheating or lying. Long waiting time, and having to struggle and be persistent to get your devices and resources. Sanctioning. If you do not show the correct behaviour, you will be penalized. Being demotivated. Working more will yield less net income, receive cuts in income or benefits. Being accused. To be seen as 'guilty' of rising costs.
6	Lack of cooperation 6.1 Hindrance 6.2 Compartmentalization	Being thwarted. Having to fight a lot to get your right, constantly having to prove that you need the requested help or care, not thinking along with you. Institutions, disciplines and departments don't work together.

7	Lack of competencies 7.1 Lack of knowledge & expertise 7.2 Lack of appropriate attitude, respect & skills 7.3 Lack of skill to treat a person as a full human being	Inexpert, ignorance. The inability to make a correct diagnosis. Lack of empathy. Lack of fairness and transparency. Not a holistic approach. Treatment instead of empowerment. Not listening. Not be taken seriously. Not be understood. Talking about you instead of with you. No trust or believe in you. Labelling, as a person being reduced to solely patient, problem or defect.
8	Lack of a realistic/fair assessment of the request for help	The illness or defects are magnified for the purpose of financial gain. Getting as much benefit as possible from someone at the expense of that person.
9	Lack of continuity in personnel	Changes in staff, and with this the change and disappearance of expertise. Continuously other professionals around you, which prevents you from building a relationship and trust.

Final findings: Results member check.

Based on our member check, all presented main categories, subcategories, and scopes of criticism were recognized by the (member check) participants. Nevertheless, participants expressed that not all descriptions fully captured the scope of their critical notes. Therefore, some alterations were made to our preliminary presentation of findings, and agreed upon by the participants. Instead of starting the main categories with 'lack of' (with the exception of 'bureaucracy') the participants preferred the expression of 'insufficient'. While the term 'lack of' has a negative connotation, 'insufficient' sounds more optimistic and according to the participants offers more room for improvement. As one participant quoted: 'Be able to move from a fail to a pass'. The participants agreed that, in general, the intentions of social policy implementers are good. They are dedicated, but also have their hands tied. Subsequently we framed the 'lack of' main categories as 'insufficient'.

Regarding the category 'bureaucracy' (5) the participants clearly voiced that this category deserves the prefix 'too much', and thus we added this prefix. The main category 'positive approach' (2) was modified into 'person-centred approach' as this better expressed the scope of criticism as well as the participants' perceived vulnerability as a real person instead of the impersonal approach. With regard to 'competencies' (7) the participants commented that here a few criticisms were missing concerning matters they experience when confronted with social policy implementers: not explaining what you are legally entitled to, and insufficient compliance with rights and obligations (e.g. compliance with privacy guidelines). We added these comments in the description of the scope of criticism.

Most debate was provoked by the description of the category 'a realistic/fair assessment of the request for help' (8). According to the participants, neither the description of this main category, nor the scope of criticism adequately covered the meaning of the criticism. Questions were raised for instance about the term 'realistic' in relation to a personal approach: 'What is realistic for whom?' Another point of discussion concerned the assessment of the request for help itself. According to the respondents, this is not a realistic or fair assessment, but a financial assessment. The assessment of the help request leans too much towards the financial situation of the institution. After extensive discussion both the main category and scope of criticism were modified. We agreed to change the main category into 'Insufficient link between care indications and the request for help'.

And last, the category 'continuity in personnel' (9). Participants expressed that cause and effect were not properly stated in the description of the main category. According to them, it is precisely due to turnover of personnel, and with this the change and disappearance of expertise, that there is insufficient continuity in social services and care provision. The description of the main category therefore was changed to: 'insufficient continuity in social services and care provision'. The member check resulted in the following final table of categorized criticisms on social policy practice:

Table 2
Outcome of member check: final list of points of criticism on social policy practice

	Main category	Subcategories
1	Insufficient self-determination	
2	Insufficient person-centred approach	
3	Insufficient social embedding	3.1 Target group / supply oriented 3.2 Alienation from society
4	Insufficient personal approach	4.1 No approachable helper, anonymity 4.2 Rules, protocols and standards driven instead of personal customization 4.3 Client file-driven instead of client-driven
5	Too much bureaucracy	5.1 High burden of proof 5.2 Distrust 5.3 Slowness, laboriousness 5.4 Penalising 5.5 Demotivating 5.6 Accusatory
6	Insufficient cooperation	6.1 Hindrance 6.2 Compartmentalization
7	Insufficient competencies	7.1 Insufficient knowledge & expertise 7.2 Insufficient appropriate attitude, respect & skills 7.3 Insufficient skill to treat a person as a full human being *Addition to scope of criticism:* Insufficiently explaining what you are legally entitled to. Insufficient compliance with rights and obligations (e.g. compliance with privacy guidelines).
8	Insufficient link between care indications and the request for help	*Modification scope of criticism into:* The financial situation of the organization is leading for assessing the request for help (economic orientation).
9	Insufficient continuity in social services and care provision	

Discussion

In this article, we presented criticisms expressed by so called 'vulnerable persons' when interacting with social policy implementers (practitioners) in the institutional life domain. We focused on these criticisms because a previous study showed that in this political-societal interactional level something remarkable occurs. Vulnerable persons perceive a significant increase of vulnerability, which they do not perceive when interacting with people in other life domains. Moreover, the richness of expressed criticisms revealed a wide variety of feelings ranging from negative towards very uncomfortable. This goes hand in hand with a high degree of deeply felt dependency of vulnerable persons when interacting with practitioners. In data obtained by in-depth interviews as well as through member-check discussions, the issue of dependency was undeniable as reflected in tables 1 and 2. This level of dependency is not at play in the context of social interaction in other life domains. Here, vulnerable persons can use strategies such as avoiding and staying away from this interaction to reduce perceived vulnerability.

The analysis of the criticisms related to the interaction with practitioners provides an insight into the causes of the significantly increased vulnerability experienced by the respondents. This insight can contribute to increased awareness of practitioners of how to improve the way they operate in interactions with vulnerable people. When applied practitioners may realize a reduction of perceived vulnerability and ease the way for vulnerable persons to live up to the socio-political norm of social participation and self-reliance, and by consequence to more social justice and social inclusion in society.

In scrutinizing the variety of criticisms and especially in the exercise of grouping these in main and subcategories, a strong overlap became obvious. For example, 'insufficient cooperation' with its subcategories 'hindrance' and 'compartmentalization' are connected with 'too much bureaucracy' and vice versa. Respondents expressed multiple nuances in their narratives which we tried to capture as completely as possible. This confirms that individual perceptions are much abundant than can be grasped in concise categories. What matters at this point is that the member check participants endorsed the final categories and subcategories.

What strikes us is that the list of criticisms mirrors most of the characteristics of a bureaucracy. A focus on rules, regulations, procedures, and protocols and the standardization of tasks and routines. Bureaucracy is the only main category without 'insufficient', but is plainly expressed as a major grievance, also during the member check. Apparently, according to the respondents, all categories except for bureaucracy carry potential for improvement aimed at reducing their perceived increased vulnerability. The only way 'too much bureaucracy' could be made bearable is by reducing it drastically.

It is worth mentioning that respondents distinguish the organisational model (bureaucracy) from implementation approaches. It is nonetheless evident that the

characteristics of the organisational model permeate some approaches of practitioners towards clients (i.e., vulnerable persons). However, respondents felt approaches from practitioners could be improved, but that a fight against an organisational model is much more difficult. If approaches of practitioners improved on the eight categories labelled as 'insufficient', it could decrease the burden of bureaucracy. Bureaucracy would then be no more than a necessary structure through which social policy is delivered. Adler and Borys (1996) talked of the 'enabling bureaucracy' versus the 'coercive bureaucracy'.

This leads us to discuss the theory about conflicting logics that are at play in social policy implementation. On the one hand, we have the so-called governmental logic, which is also permeated by a market logic. On the other hand, we have the so-called social logic (Klamer, 2017; Bakker-Klein, 2019). The governmental logic is a formal logic in which values such as fairness, rightfulness and consistency are key. There is nothing wrong with these values, except if these values are solely operationalized in a bureaucratic manner. Then the promising values tend to be lost in rules, protocols and standards. This is exactly what the respondents addressed in their expressed criticisms: there is 'too much bureaucracy'. The social logic is an informal logic in which moral-ethical considerations are predominant. Provided that practitioners operationalize these considerations correctly, individual interests of persons with a request for help will be considered.

In addition to the conflicting logics, social policy implementers also have to deal with an overload of policy tendencies created by social policy makers. In the literature, besides bureaucratization, these are managerialism, accountability, conditioning and sanctioning (Vandekinderen et al., 2018). These policy tendencies not only overburden the bureaucratic organisation, but even worse they threaten the universal, open and unstructured nature of social rights and the access to these rights. Social rights such as the right to a level of social security, through support, care and provision of resources, by means of which the government guarantees the well-being of citizens to be able to participate and be self-reliant and ultimately to be included in society (Vandekinderen et al., 2018).

Practitioners, who are the agents of social policy, are bound by schemes, structures, standardized approaches, and policy tendencies. When practitioners are confronted with vulnerable persons who expect moral-ethical considerations (the social logic), these policy tendencies, contained in governmental logic, obstruct the weighing of individual interests (Stam, 2013; Duyvendak and Van der Veen, 2014; Frissen, 2014, Rotmans, 2014; Bakker-Klein, 2019). This is also reflected in tables 1 and 2. When the social policy implementer is exclusively a '(bureaucratic) puppet on a string', his or her mission is 'doing things right' (Vandekinderen et al., 2018).

Social policy implementers who to a great extent apply the moral ethical considerations (the social logic) more represent the 'puppet player' and are more likely to respond to the specific requests for help and facilitate access to social rights, benefits and services. In short, he or she is 'doing right things' (Vandekinderen

et al., 2018). A study of Bakker-Klein (2019) aimed at exploring practices of social policy implementers, confirmed that social policy implementers showed willingness to distance themselves from the governmental logic and claimed to operate more sensibly in handling social logic. These findings reflect to a high degree our respondents' opinions with respect to their experiences with social policy implementers.

First, in the member check session the proposed judgement or 'lack of' was toned down and replaced by the label 'insufficient', which sounds more positive, offers room for improvement, and represents respondents' experiences accordingly. Second, member check participants agreed that in general the intentions of practitioners are good. They are dedicated, but also bound hand and foot. Respondents confirmed that to find a balance between governmental logic and social logic is not an easy task. They indicated that regulations are complicated and blurry, and that they make high demands on clients as well as on practitioners. Both vulnerable persons and practitioners are to a more or lesser extent victims of the same overly bureaucratic regulations and policy tendencies. This raises the question whether and to which extent social policy implementers working in a bureaucratic organisation are '(bureaucratic) puppets on a string' or 'puppet players'? In other words, do they have a say in how social policy is implemented? The key issue remains if and to what extent the social policy objectives are achieved? In seeking an answer to this question it makes sense to examine some other relevant theoretical insights. These are the concepts 'underprotection' and 'non-take up', both in relation to 'availability' and 'accessibility' of social rights; benefits and services.

'Underprotection' refers to the phenomenon that people do not realize their fundamental social rights, including the right to financial benefits and the right to a public offering of rights and services (Eeman et al., 2013). It relates to the phenomenon of 'non-take up'. Van Oorschot (1995, p. xi) defines non-take up as 'the phenomenon whereby people or households do not receive the amount of financial benefit to which they are legally entitled'. Although 'underprotection' takes a broader approach than non-take up, both phenomena indicate an ineffective implementation of social policy. They imply that social policy objectives are not or not fully achieved for all or some citizens (Van Oorschot, 1995; Eeman et al., 2013). In the domain of social policy and in searching for causes of 'underprotection' and 'non-take up', three levels of stakeholders are involved: social policy makers, social policy implementers as well as clients. All play a causal role (Van Oorschot, 1995; Ypeij and Engbersen, 2002; Eeman et al., 2013). With vulnerable persons, we wonder what their causal role might be. Here a closer examination of the concepts 'availability' and 'accessibility' may help. In the literature 'availability' is described as poor, delayed or partial implementation of social rights, benefits and services. With respect to 'accessibility', benefits and services are indeed available, but due to the complexity of regulations difficult to procure (Van Oorschot, 1995; Ypeij and Engbersen, 2002). In theory, potential clients may not be aware of how and which

social rights are available and if they do know, may not ask for help (Van Oorschot, 1995; Ypeij and Engbersen, 2002; Eeman et al., 2013). It goes without saying that social rights are not accessible for this group of citizens. They remain 'underprotected' and need a programme aimed at assisting them in how to access and take up the social rights they are entitled to.

With respect to our study population, they knew which rights, benefits and services were available. They were empowered enough to access these social rights. However, it appears to be extremely difficult to get them. Not only due to the bureaucratic regulations and policy tendencies, but also due to insufficiency in implementation approaches (see Table 1 and 2). These respondents may even get close to the point of non-take up, but cannot be held responsible for that. In fact, they are eager to take up their rights, they also do so, and therefore were able to analyse the social policy implementation system.

Given the fact that they have take-up and are thus in theory socially protected, the main point of their criticism seems to lie in the application procedure to appeal for social rights. Apparently, the feeling of being underprotected starts from the very outset of the interaction with social policy implementers. Given our respondents' narratives, in the interaction with practitioners it is not so much what you achieve, the take up of social rights, but more importantly the way you are treated. The consequence of the feeling underprotected by practitioners is a perceived increased vulnerability. The practitioners on which clients depend to access social rights to live up to the social political standard, are exactly the persons who obstruct it and cause clients to remain in the group of vulnerable people. This can also lead to clients not completing the process of taking up social rights, resulting in non-take up and a situation of not being socially protected.

It is also quite possible that underprotection in the institutional life domain has a negative influence on other life domains in which people from vulnerable populations operate and interact with other people. Being insufficiently protected socially could cause them to also withdraw from other life domains, resulting in continued social exclusion. To reach social policy practice objectives, the tide needs to turn in the implementation system and also in social policy implementers' approaches. Access to social rights in principle should equal access to social rights in practice.

Several challenges present themselves for practitioners. First, the predominance of the governmental logic and growing policy tendencies calls for a strong counterbalance of the social logic. Practitioners could act more as a 'puppet player' instead of a '(bureaucratic) puppet on a string'. Without losing their role as agents of social policy makers, practitioners should concentrate primarily on clients' needs. By putting their clients first, they are more likely to 'do the right things' while conforming to the necessary regulations, protocols and budget constraints ('do the things right)'. Second, when acting in this way, practitioners are 'responsive'. Bakker-Klein (2019) describe this as estimating what is really of significance for clients, listening to and empathizing with them. Provided that the above is realized, the situation of

dependency, hierarchy and imbalance between asking for versus providing support disappears. What appears now is an equal partnership in which dialogue evolves (Vandekinderen et al., 2018). Third, ideally, 'responsiveness' should coexist with 'proactive behaviour', meaning that practitioners reach out for their clients, assist and facilitate their clients from the beginning until the (very) end of the application process. This is what Eeman et al. (2013) label as an offering government and organisation. The initiative to realize rights and services lies primarily with them instead of with the person requesting help. We assume that vulnerable persons will experience a decrease of vulnerability, less dependency and will feel more at ease. Fourth, in addition to proactive behaviour, practitioners should claim more discretionary space, i.e. the space to take decisions and act according to one's own insight in concrete cases within the limits of the law even when it deviates from the prescribed procedures and rules (Lipsky, 1980; Vandekinderen et al., 2018). This is exactly the space where a practitioner can act as a 'puppet player' without ignoring the social policy regulations. In this situation there is room for 'doing the right things right' in favour of clients. A final challenge for practitioners is to reflect on their position as liaison officers between clients and policy makers, and vice versa. If the existing bureaucracy remains merely a structure for delivering social policy with ample possibilities for discretionary space, this liaison function towards social policy makers does not call for much attention. When policy tendencies hinder the access to social rights, practitioners should take up their mediating role on behalf of their clients by informing social policy makers accordingly.

Responsible practitioners should transform the issue of underprotection from (individual) client level into a collective and public issue (Spierts, 2014; Vandekinderen et al., 2018; Hermans et al., 2019). Just like our respondents fulfil a mediating role by giving voice to other, often silenced vulnerable persons in society not participating in this study, practitioners could follow this role model.

With regard to methodological issues, both the sampling technique and the research methodology imply that the study findings cannot be generalized to represent the whole population of vulnerable persons. The value of the application of in-depth interviews and use of a grounded theory approach (emergent design) provided us with a wealth of data leading to an unexpected insight into vulnerable persons' experiences and criticism on social policy practice. Insights that are relevant either for scientific or practice-oriented knowledge building or for both. Although the limited scope of this study provided richness in data, we acknowledge that other stakeholders, such as social policy implementers and vulnerable persons with other ethnic backgrounds, should participate in forthcoming studies on social policy practice. Nevertheless, provided that the value of the insider's perspective is recognized by social policy implementers, there is potential for improvement processes aiming at realizing the desired outcome for all parties of an inclusive society and therefore social justice for all citizens.

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