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Chapter 6

Alignment and service user participation in low-threshold meetings with people using drugs <1>

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The chapter:

- examines multi-agency meetings in low-threshold services for people using drugs in Finland;
- applies the concept of alignment as a linguistic device in which meeting participants cooperate in interactions;
- argues that markers of aligning make the interaction flow in a cooperative direction;
- demonstrates how meeting participants in agenda-setting and decision-making sequences work towards collaborative service user participation;
- approaches the data extracts as examples of collaborative service user participation accomplished as an interactional achievement in situ;

- finds that, for example, question-answer sequences and positioning both service users and professionals in alternating ways as ‘tellers’ and ‘recipients’ are essential alignment techniques to advance collaborative participation;
- makes visible how collaborative participation is never completely but partially achieved and at risk of failing.

Introduction <2>

Since the 1980s, service user participation[1] has been a widely discussed ideal among politicians, social and healthcare professionals and service users themselves (for example, Velasco, 2001; Kvarnström et al, 2012; Finset, 2017). Service user movements have highlighted participation as an issue of freedom of choice, human rights and self-determination (for example, Cook and Jonikas, 2002; Raitakari et al, 2015; Lakhani et al, 2018; Chapter 2 in this book). In general, the concept signifies that service users play an important role in directing social and healthcare service systems as well as their personal service pathways. Additionally, service users are portrayed as evaluators, informants, consumers, decision makers, experts-by-experience, or collaborators in professional encounters.

Western policies emphasise that services and multi-agency collaboration should be pursued in a way that strengthens service user participation (for example, Thomas, 2010; Fox and Reeves, 2015; Chapter 2 in this book). However, there is conflicting knowledge on how this aim is actually realised at frontline practices of social and health care (for example, Kortteisto et al, 2018; Chapter 2 in this book). Multi-agency collaboration is a challenging way to realise participation because it requires various competencies, such as the capacity to express oneself, to consider the stances of other parties and to cross potential barriers, such as poor communication and lack of respect (Hopwood and Edwards, 2017; Naldemirci et al, 2018).

Alignment and service user participation

In this chapter, service user participation is examined through interprofessional interactions in multi-agency meetings in Finnish low-threshold substance use services. The aim is to scrutinise interactional practices that strive to strengthen collaborative the service user participation of vulnerable groups.[2] Hence, our approach differs from previous studies that have constructed various conceptualisations of service user participation[3] (Arnstein, 1969; Hickey and Kipping, 1998) or barriers involving service users in their service pathways (for example Borg et al, 2009). Some studies have examined service user participation in multi-agency working either exclusively theoretically (Fox and Reeves, 2015), or in conjunction with service user interviews (Thomas, 2010; Kvarnström et al, 2012), or through analysing interactional data from multi-agency meetings (Juhila et al, 2015; Koprowska, 2016), as is done in this chapter.

Collaboration requires sufficient sharing of institutional agendas and decisions, and aligning with one another's views and aspirations in interactions. Collaborative participation can thus be distinguished from participation that is based on acting as an individual consumer or advocate within the services. In the analysis section, how collaborative service user participation is bound to particular interactional activities is considered, especially alignment. More precisely, it examines: 1) *How the participants of multi-agency meetings align themselves and others as collaborators* and 2) *How service user participation is thus potentially realised in agenda setting and decision making via alignment during meeting interactions.*

The chapter proceeds in the following way: first, the context and standpoints of the vulnerable clients are introduced. Second, it explains how acts of alignment are approached as indicators of collaboration and the related possibilities for service user participation. Before the results and conclusion sections, the use of data and the process of analysis are elaborated. The focus throughout the chapter is on doing collaborative service user participation while setting the agenda and making

decisions in low-threshold meetings with people using drugs. The multi-agency meetings studied are ad hoc review meetings in the sense that they are arranged when they are deemed beneficial for managing the service user's service pathways. They are not routine fixtures in the service organisations, as weekly team meetings would be (see Chapter 3 in this book for organisational routines and integration ceremonies).

Low-threshold substance use services and vulnerable status <2>

Substance use services in Finland have undergone a major shift towards increasing multi-agency collaboration and a stronger drive towards service user participation. For example, the law on substance abuse (41/1986, 9 §) states the importance of collaboration between various services, ranging from health and social care to housing and employment authorities. Furthermore, the obligation to enhance service user participation is articulated in the policy documents of the Ministry of Social Affairs and Health (2009) and the National Institute for Health and Welfare. This has increased opportunities for people using drugs to become more powerful actors in shifting institutional contexts (see Ranta, forthcoming).

However, the illegality of drug use and its everyday risks, along with discrimination and marginal societal status, may limit service users' opportunities and competency to act as active and independent decision makers in their own lives. It is known that people in marginalised positions 'may have such severe experiences of oppressive and violating encounters with other people and societal institutions that their self-trust and autonomy competencies have gradually diminished. Feminist scholars talk about reduced self-trust in these kinds of circumstances' (Juhila et al, 2020, p 3; see also Dodds, 2000; McLeod and Sherwin, 2000). Potential violations of one's autonomy and low self-trust may also have a significant influence on one's ability to act as a collaborator in multi-agency meetings. Accordingly, the assumption is that active drug use creates constraints for assuming a position of strength in multi-

agency meetings, and when aspiring to collaborative service user participation, these constraints need to be taken into consideration.

A weakened ability to function also makes people using drugs structurally vulnerable (McNeil et al, 2016), as they can face different kinds of 'treatment barriers' in health and social care (Notley et al, 2012). Low-threshold services, which are the context of this study, are one way to overcome obstacles in receiving support from the 'main stream' service system. Low-threshold services reach citizens who are hard to reach in other health and social care services (Notley et al, 2012). The concept 'low-threshold' also refers to client-centred and easily accessible services with no bureaucratic obstacles or a requirement for abstinence. It is assumed that multi-agency working between low-threshold services and other service providers can promote participation and mitigate the vulnerable position of people with multiple service needs. For instance, low-threshold services can operate as gateways to services with stricter requirements, thus enabling appropriate transitions in personal service pathways. In sum, the upcoming analysis makes visible the possibilities and limitations of collaborative service user participation among people whose competence is compromised, whose societal status is vulnerable and who have difficult life experiences, including rejections by welfare services.

Service user participation – shifting alignments <2>

The presumption of the analysis is that taking a particular position in interactions may either advance or hinder the degree of service user participation realised in collaboration. Thus, collaborative participation is understood as a negotiable, 'elusive' and fluid process where participants take various shifting positions, such as 'teller' or 'knower'. Participation also appears when participants align with others to get acceptance for their stances or to influence others' views. When collaborative participation takes place, alignment occurs in such a manner that service users can, at least to some

extent, obtain active and valued positions in interactions, as well as influence agenda setting and/or decision making. Alignment and mutuality can be seen as core elements of collaboration (Edwards, 2017).

From this it follows that collaboration and related opportunities for service user participation are understood as acts of *alignment.* According to Juhila et al (2014, p 119), alignment refers to 'mutual cooperation among professionals and service users, where both are oriented to similar institutional tasks and interactional agendas'. Hall and Matarese (2014, p 85; ref. Stivers 2008, pp 34–35) define alignment as follows: 'displays of support of the hearer and endorsement of the teller's conveyed stance'. Affiliation is thus *emotionally realised alignment*, for example, by displaying empathy (Steensig, 2013, pp 1–2; Kykyri et al, 2019, p 3). Affiliation entails reciprocity, engagement and intersubjectivity. The definition of the concept of 'alignment' used in this text comprises affiliation, that is, an 'affective level of cooperation' (Stivers et al, 2011, p 20; see also Stivers, 2008; p 53; Kykyri et al, 2019, p 3)

One way to express alignment is to position oneself and others in a particular manner in an interaction. *Positioning* is a discursive achievement, which is constrained and made possible by moral expectations and cultural discourses perceived relevant by the participants. A position is a moral stance that includes expectations of one's rights, restrictions and responsibilities as an actor in the interaction (Wetherell, 1998; Selseng and Ulvik, 2018, pp 17–18). Language use reveals how one is positioning oneself and others in a given interactional situation. For instance, one may take a position of a 'bystander', 'leader', 'expert' or 'accused one'. When analysing the data, it is identified markers, such as positive, minimal responses like 'yeah', that display potential (emotional) support for the service user's or professional's viewpoint. The service user may strengthen his/her position as a collaborator by going along and supporting the professional's views, or the professional equally may

support the service user's position by going along with his/her views. In general, markers of aligned positioning make the interaction flow in a like-minded cooperative direction at the given moment.

Data and the process of analysis <2>

The data in this study comprise nine audio-recorded naturally occurring multi-agency meetings from two Finnish low-threshold services targeted at people using drugs[4]. In the first setting, an outpatient clinic (seven meetings), the focus is on comprehensive psychosocial support. This includes both one-to-one supportive discussions and collaboration with other services, such as housing support, adult social work and psychiatric services. The other setting, a floating support project (two meetings), aims to reduce individual and societal risks due to drug use and increase the participation of people injecting drugs. The focus is especially on housing and avoiding the risk of homelessness. Hence, the work entails doing home visits and collaborating especially with the local housing company, adult social work and the Social Insurance Institution.

In both research settings, a common way for collaboration to occur is to arrange multi-agency meetings whenever they are deemed useful to steer the service user's often-complex life situation and service pathways. The meetings have several institutional tasks, such as reviewing the service user's current (problematic) situation, making service choices and preparing for the service user's transition to a new service or housing arrangement. The themes discussed are related to drug use, housing, financial matters, mental health and other everyday issues. The participants know each other in advance – the low-threshold professionals especially have well-established relationships with the service users. When the participants know each other, the meetings have more informal features, for example turn-taking more often resembles everyday conversation (see Chapter 3 in this book). The meetings do not have a named chair with a clear role to steer the meeting encounter or a strict, prewritten agenda (which differs for example from Care Programme Approach meetings in England,

Chapter 8 in this book). As a result, the participants themselves can select the next appropriate speaker and potentially change the topic (see Chapter 3 in this book), hence, in the following analysis, agenda and topic are used as parallel terms.

According to Peräkylä and Ruusuvuori (2007), it is crucial that participation is realised in each phase of the service user encounter. They present five different components of patient participation, including patients' 'contribution to direction of action', 'influence in the definition of the agenda of the consultation', and 'influence in decision-making' (2007, pp 167–9). Other research argues that agenda setting, decision making and choice are crucial, yet complex elements of service user participation (Matthias et al, 2012; Juhila et al, 2015).

In the first phase of the analysis, using the ATLAS.ti program, the whole dataset was worked with to code all instances where either *the agenda for the meeting* or *decisions concerning the service user's current or future situation* were discussed. The coding confirmed that the structure of the meetings was not linear but spiral, due to their informal nature (see Chapter 3 for structures of meetings). This spiral informality was manifested in, for example, shifting topics that were re-discussed several times during each meeting. It also emerged that the position of the leader moved between professionals according to the topic under discussion. The professional who took the lead had the greatest expertise concerning the particular domain. In addition, instead of distinct 'decision-making' sequences, decisions could be made during different phases of the meetings. Decision-making sequences refer to instances where participants concluded everyday matters, such as when the service user could fill in social benefit forms or what topics would be addressed next. Living arrangements or future service choices were also negotiated. Sometimes it was left open whether a decision had actually been made, in that the decision was tentative and partial in nature (see Chapter 3 for a distinction between decisions and the decision-making process).

Alignment and service user participation

Ultimately, it was discovered that service user participation was chiefly accomplished by setting the agenda and making decisions collaboratively. The meetings allowed and required the participants to align in striving for collaborative service user participation. It seemed that in these particular low-threshold settings, professionals were committed to strengthening service users' abilities to act as collaborators during the meetings and thus potentially mitigate their vulnerable positions. Service users did not participate in the meetings by, for example, 'exiting' the services, complaining or taking the position of a 'consumer' (for the distinction between exit and voice in participation, see Pickard et al, 2006). The professionals' drive to align with the service user and their support for collaboration can be recognised from expressions where, for instance, they:

1) accept the service user's initiative regarding the topic;

2) ask the service user's opinion regarding practical arrangements;

3) express affiliation.

Examples of these discursive practices are discussed later in the chapter.

In the second phase of the analysis, four theoretically relevant data extracts were analysed by utilising the analytical concept of alignment. We concentrated especially on the discursive markers of alignment as they are displayed in the data. In addition, we paid attention to professional and institutional factors that may set limits and explain particular types of alignment, and through that, participation. The first two extracts display agenda setting and the latter two decision-making sequences.

Analysis: doing collaborative service user participation while setting the agenda and making decisions <2>

Service users cannot be active by themselves in institutional settings, as an interactional space and encouragement given by the professionals is required (see Ranta, forthcoming). Thus, service users' abilities to influence the meeting agenda and decision making are dependent on professionals' interactional competence and practices. However, service users' competencies and interactional moves are significant factors that influence how professionals conduct their institutional task-based work. Thus, the following analysis approaches service user participation as an interactional achievement.

Defining the agenda and the course of interaction <3>

Extract 1

Adam is currently homeless and has been visiting the outpatient clinic for several years. Before the multi-agency meeting, Adam met the outpatient clinic's social worker, and they discussed how to proceed with his housing issues. Adam (A), the municipal adult social worker (ASW), the outpatient psychiatrist (OP) and the outpatient social worker (OSW) are having a meeting concerning Adam's situation. The data extract is from the beginning of the encounter.

1. OP: How are you, Adam?
2. A: It's like from one state to another. My mood kind of worsened when I saw my big brother after a really long time when he got back from [name of the place where he had completed national civilian service], and he told me about this thing that I remembered when I was five or six years old, that rape thing that I remembered. So, he told me that it wasn't a one-off case. That it happened when I was three years old, but it was another person at that time. This person was my cousin.
3. OP: How much older was s/he then than you, this cousin?
4. A: About 10 years.
5. OP: Yeah, okay, a definite act then. So, how are you dealing with it now? Have you been thinking about it a lot, or how?

6. A: Well, I mean, occasionally some things have come into my mind, but I don't want to get into it.
7. OP: It's completely okay. We're dealing with present-day issues here.
8. A: Present-day issues.
9. OP: Just one thing, Adam. We raised your Concerta dose ((medication for ADHD)) last time we met. Did you notice any changes in your condition?
10. A: Well, I mean, yeah. I can function better in the evenings.
11. OP: Good, so it worked as it was meant to.
12. A: Yeah.
13. OP: Good, that's good. So we can probably orient to your social]
14. OSW: [Yeah, and to your everyday life, how it's going. Yeah. Last time we talked about this homelessness issue with ((name of the landlord of local housing company)). Adam hasn't had a flat to live in for six months, a bit more than six months, right?
15. A: Mm.
16. OSW: It was very moving when you described what it means when you're trying to find a place to stay at night.
17. A: Yeah. Few nights back, I slept in an accessible toilet at the railway station, as I couldn't find a place to sleep, and my phone didn't work either. So, I slept there.
18. OSW: There would certainly be places that are more comfortable.
19. A: Yeah. There would. (5) A home of my own would be the best, but.
20. OSW: There's this contradiction or difficulty then, as you said that it would be a bit terrifying for you to live alone?
21. A: Yeah. I'm afraid that I'm kind of losing control. And then my own home, especially keeping it clean and maintaining the things and stuff, it's a lot of trouble.
22. ASW: I agree with that, we have tried that.
23. OP: Right.
24. ASW: And already back then, you were also afraid of moving in on your own. And then it turned out that it didn't, that you couldn't handle it, living alone.

The OP uses the opening turn to ask Adam how he is doing, encouraging him to speak. In this way, he invites lay experience talk and shows that he is interested in Adam's meaning making. Adam is positioned as a teller with relevant knowledge and experience that will be heard first in the meeting. Adam aligns with these expectations and the agenda by describing his feelings and traumatic childhood incidents. He expresses competence in narrating his experiences in a multi-professional interaction and by directing the agenda towards therapeutic issues. The OP supports this by asking for additional information (turn 3) and validates Adam's account by stating that what had happened

really was a rape, “an act” (turn 5). He also expresses emotional alignment by showing that he cares and is thus interested in hearing how Adam is coping with the burden. The turn-taking fits well with institutional-professional expectations of a psychiatrist’s position and expertise. Next, Adam states that he wants to change the agenda (turn 6). The OP aligns in an empathic way with him and accepts the topic change (turn 7). He gives Adam the right to set boundaries concerning discussions about his life.

The topic shift is indicated when the topic of “present-day issues” (turn 7) is formulated by the OP. Adam aligns with it by repeating the new agenda (turn 8). The chosen topic seems to fit all participants. It can be assumed that handling present-day issues is in line with the institutional task of the clinic and the current meeting. The OP continues in the leading position by choosing medication as the next topic of discussion (turn 9). From there, an alignment sequence starts (turns 10–13), during which both Adam and the OP express positivity, and they support each other’s views and interpretations. They both have privileged access to psychiatric knowledge, yet only Adam has personally experienced the medication change. This makes him a valuable informant and collaborator (see Chapters 8 and 9 concerning epistemic rights in this book), and he is thus capable of interacting according to the expectations related to this position. Next the OP gives space to social issues by suggesting a topic change (turn 13).

The OSW overlaps and takes a turn immediately, interpreting that topic change back to everyday issues requires her to take the lead (turn 14). She reports Adam’s homelessness history that she verifies with Adam by giving him an opportunity to reflect on her description. Adam seems to accept the OSW’s interpretation with a minimal response (turn 15) and she continues by displaying alignment and expressing emotional support for Adam’s demanding life situation (turns 16 and 18). She also shows that she remembers and values the stories Adam has told (turn 16). These interactional

acts make it possible for Adam, first, to take a position of a valuable reporter of his homelessness history (turn 17), and second, to position himself as a service user who can express his own wishes (turn 19).

It is notable that the social workers do not support Adam's position as 'dreamer of a home of his own'. Instead, they choose to shift the topic to the difficulties anticipated in Adam having his own home. Both the social workers and Adam jointly make a problem formulation concerning the difficulties of living independently (turns 19–24). Adam expresses a "but" in his wish for independent living (turn 19), and thus creates an opening to discuss the difficulties related to his housing. The social workers align with this change from hopeful future talk to problem talk. In turn, Adam accepts the social workers' interpretations of his contradictory feelings, difficulties and fears and is competent in describing them in detail (turn 21). A strong marker of alignment is the ASW's agreement with Adam's problem formulation (turn 22). Turn-taking also reveals how the social workers have previous knowledge of problematic issues. Hence, they can share the difficult experiences with Adam and take the position of 'problem formulators' (see Chapters 8 and 9 concerning epistemic rights in this book). Adam is jointly positioned as someone with personal difficulties that hinder him from exiting homelessness. The positioning in this trouble talk sequence may reflect the social workers' institutional task to recognise potential risks in the service user's life, and the expectation for the service user to be open about his troubles.

The extract implies a degree of collaborative working between the professionals and the service user, who is in a strong position to make topic changes and problem formulations. The professionals align with the service user by accepting his views and showing emotional support, while the service user aligns with topic changes made by the professionals as well as their interpretations concerning his constraints. It can be concluded that participation is realised through mutual alignment and

collaborative agenda-setting practices, yet the professionals take the leading position in selecting topics as part of their professional-institutional roles.

Extract 2

Alex has experienced long-term and recurrent homelessness during the course of his life. Before the multi-agency meeting was arranged, he had just learned that he had been allocated a flat by the Housing Support Unit. Alex (A), the outpatient clinic's social worker (OSW) and the housing support worker (HSW) are discussing Alex's situation together.

1. HSW: We ((Alex and HSW)) talked a bit about the thoughts that have come up about getting a flat from ((a name of the Housing Support Unit)), and I was thinking if you'd like to tell ((us)) about your own thoughts now.
2. A: Well, no. (4) Perhaps it causes a bit of pressure about do I manage to keep it. Not major pressure, just some thoughts.
3. HSW: So, it's more like being worried about whether you can do it.
4. A: Yeah.
5. OSW: Do you remember when the last time was that you had a flat of your own? It was probably there (2). Did you live in ((name of the neighbourhood)) back then?
6. A: Yeah.
7. OSW: It was quite a number of years ago.
8. A: It was, yeah.
9. OSW: Do you remember how long?
10. A: Four or five ((years)) ago, possibly.
11. OSW: Yeah, since then, you've been homeless and lived in all kinds of housing arrangements. I checked; I tried to search on our computer for the kinds of issues there have been, and I checked that you visited us here in the outpatient clinic for the first time in 2002. This probably describes, how would you say it, like, the difficulty or complexity of your situation from the point of view of the authorities, probably not your own view, but for the authorities. Alex's treatment is being tossed back and forth within our services ((refers to the NGO)) as well. And you've occasionally been in ((the outpatient clinic for people using alcohol)), and occasionally in here ((outpatient clinic for people using drugs)), and it's like 'eeny meeny miny moe', which place is responsible for your treatment, and who is responsible in the end. It's been something like that, hasn't it?
12. A: Yeah.
13. OSW: And you've occasionally asked if you could move to the ((outpatient clinic for people using alcohol)) and then they've moved you back here. So, this is, I sort of wished that ((name of municipal's commissioner service)) was here, to see that this kind of fragmentation of substance use treatment is happening here ((in the NGO)) as well. Even though we are part of

the same organisation, we are still searching for the ((right)) place for the person to be treated. Somehow, there has always been this question of what your primary intoxicant is.

14. A: Yeah.
15. OSW: And has the drug use always been secondary and the alcohol use is primary? Isn't that how it is?
16. A: It has been pondered and thought over, I guess.
17. OSW: Yeah, what do you think about it today?
18. A: It is alcohol that comes first now.
19. OSW: Yeah, that's how I've seen it all the time. And when it begins, the drinking, other issues arise.
20. A: Mm.
21. OSW: But it all starts from drinking then, after it gets going then.
22. A: That's how it starts, yeah.

The HSW opens the meeting by referring to a discussion she has previously had with Alex and gives Alex the opportunity to talk about his thoughts in more detail (turn 1). Alex is addressed as a knowledgeable participant capable of expressing his feelings related to the housing transition, the main agenda of the particular meeting, and in this way, to direct how the topic is formulated and handled together further on. Alex first hesitates and refuses to take the leading position in the interaction. However, after a long pause, he uses the offer being made to take the next turn to talk. (Conversation analytical work has previously demonstrated that delays in an interaction indicate hesitation and trouble, for example, Stivers et al, 2011, p 22.) He defines the current housing transition as causing "pressure" resulting from the uncertainty related to his ability to sustain his housing (turn 2). The HSW aligns with Alex's problem formulation by repeating it in a slightly different form, and in this way, checking that she has understood it correctly (turn 3), which Alex then verifies (turn 4).

From then onwards, the OSW takes a strong leading position: she begins to put Alex's sense of pressure in context, and in this way, makes it more understandable and acceptable. She asks Alex about the duration of his homelessness history and his last home (turns 5, 7, 9 and 11). The OSW and Alex's joint homelessness narration changes the topic from present-day pressures to past homelessness pathways. The OSW is in the positions of 'narrator' and 'questioner', and Alex aligns

with this by taking the positions of ‘verifier’ and ‘answerer’. Alex’s participation is realised by only using minimal responses and scant descriptions. This can be interpreted in many ways: minimal responses can indicate a client’s passive resistance, a ‘voiceless’ and powerless position both in the meeting and in society. Minimal responses can also mean that Alex trusts the OSW’s competence to talk on his behalf. Although in a minimal way, Alex goes along with formulating the topic in the professional-led question-answer turn-taking format (turns 6, 8 and 10) (for more on question-answer sequences, see Peräkylä and Ruusuvuori, 2007, p 169; Chapter 3 in this book).

The OSW continues contextualising Alex’s situation in an understanding way as she describes difficulties from the point of view of the authorities and service systems (turns 11 and 13). She constructs Alex’s past treatment pathway as fragmented, including confusion about responsibilities and thus bouncing Alex back and forth between alcohol and drug treatment services. He is positioned as a ‘victim of the system’ and the blame is directed at others. In this way, the OSW implies that she understands the reasons for Alex’s situation and avoids blaming the service user. She sets herself in the position of a professional who knows the existing problems in the service system and has followed Alex’s transitions between different services for a long time. Thus, she seems to have a mandate to explain possible obstacles to his receiving proper treatment. However, she checks that Alex shares her views on the topic (turn 11). Alex seems to align with the problem formulations by using minimal responses (turns 12 and 14), yet these responses are difficult to interpret in an unambiguous way.

The next agenda change is marked by the question about Alex’s primary intoxicant (turn 13). The OSW’s question shifts the discussion from the service system to Alex’s alcohol and drug use and the relationship between them (turns 13–22). She strongly suggests that drug use has been secondary for Alex and alcohol is the primary issue. She asks for Alex’s view about this by using a leading and fixed-choice question (turn 15). Interestingly, Alex does not take a clear stance, but replies in the

third person, positioning himself as a ‘bystander’ and an ‘outsider’ (turn 16): it is something that has being thought over by others. The OSW may recognise this passive positioning as she repeats the question, asking Alex for his own opinion (turn 17). After this insistent interactional act, Alex formulates alcohol as the problem that “comes first” (turn 18). The OSW strongly supports and aligns with this opinion and displays a causal account, that it is the alcohol that triggers other troublesome issues (turn 19 and 21). In turn, Alex verifies this and goes along with this interpretation (turns 20 and 22), so the problem formulation is not disputed but accepted by both participants. However, a critical question can be asked about whether it becomes too demanding for the service user or the HSW to resist and disagree with the professional when she is controlling the topics and stating her opinion so strongly.

In sum, the extract demonstrates professional-led collaborative service user participation that is based on the professional’s expert position and long relationship with the service user. Participation is potentially advanced when the professional narrates the service user’s problematic service pathways in a respectful way and the service user confirms professional conclusions by using minimal responses. The professional’s ‘narrating work’, that is, talking on behalf of the service user (see also Chapter 8), may be seen as helping the service user to formulate his case (see Naldemirci et al, 2018). Alignment is expressed by using positive responses that imply like-minded thinking. However, reflecting critically, as the professional is the more powerful participant, she may potentially override the service user’s (as well as the HSW’s) voice and rely too much on what she knows about the service user’s reality. She is aware of institutional preconditions that set limits on the service user’s treatment and housing options. The service user’s meagre responses may not indicate agreement so much as a vulnerable and passively resistant position in the welfare system and in the current meeting.

Making decisions and choices <3>

Extract 3

Max has been living at his mother's place due to homelessness, and he has been looking for a flat together with the floating support workers. The floating support workers (FSW1 and FSW2) have invited Max (M) and a landlord from the local housing company (HC) to discuss Max's housing situation. During the meeting, the landlord and Max discuss the new flat and the rental contract. The participants are making final decisions.

1. HC: Good. We'll just wait ((until the new flat is available)). But I assume you'll take the flat?
2. M: Yeah, there's no problem, of course.
3. HC: Let's book it for you then, so it's promised. The booking day is today, so it's all done now.
4. M: Yeah.
5. HC: Let's put it on the computer.
6. FSW1: Okay. How are we going to proceed with the rent security deposit issue then? Would you like to?
7. FSW2: An electronic ((application)) for the Social Insurance Institution is needed, now rather than later.
8. FSW1: Do you, would you like to start to do it now?
9. M: Yeah, I, whatever suits me.
10. FSW2: It's, but the bank statements. They should be printed from the online bank service.
11. M: Is it better that the disability pension has been paid to my account or worse that it has not been?
12. FSW2: It doesn't]
13. M: [I just received the pension.
14. FSW1: Your pension income doesn't matter.
15. FSW2: It is not that meaningful, as you don't (2). The application is for 1,100 ((euros)), that is the rent security deposit. After 1,100, you should have 500 left that you are entitled to, the spending money.
16. M: Does it matter whether we do it today or tomor]
17. FSW1: Are you up to it ((now))?
18. M: Yeah, I mean]
19. FSW1: [But we're here tomorrow, what day is it today? Wednes]
20. M: Wednesday.
21. FSW1: Aren't we here tomorrow? Yeah. So, it's up to you, what's your own ((opinion))?
22. M: Well, it would of course]
23. FSW2: [If you have the energy to do it, let's do it right away.

24. M: We can do it, yeah.
25. FSW2: It's only]
26. M: [I should have the bank's user name and password and stuff.
27. FSW2: Takes quarter of an hour]
28. FSW1: [And then it's done.
29. M: It would be better of course if it was done.

HC outlines the next steps in the housing pathway and asks Max to make the first decision: whether to take the flat being offered or not (turn 1). Max is thus put in the position of a choice-maker in the interaction. He goes along with HC's assumptions and accepts the offer (turn 2). It can be anticipated that Max has only limited options, and as a result, is a vulnerable position in local housing markets. This may be why he seems so sure about taking this particular flat. HC decides to make the booking arrangements on site via a computer during the conversation (turns 3 and 5), which Max seems to support with a minimal response (turn 4).

As the decisions to rent the flat and make the booking arrangements have been made, the floating support workers take the leading position and change the topic to the bureaucracy of getting income support for paying the required rent security deposit. During the conversation, Max is given an opportunity three times to decide how and when to proceed with the application process (turns 6, 17 and 21), yet both floating support workers strongly suggest taking care of the matter immediately (turns 7, 23, 27 and 28). The questions display empathy and emotional alignment towards probably an exhausted Max, who needs to get through the bureaucratic process. Max is hesitating about whether to fill in the application right away or later (turns 9 and 16). He positions himself as a consulting collaborator: he will proceed with the application as it is deemed best in his situation. The participants seem to conclude that it is better to write the application right away, and in this way, they direct Max's decision making. The decision about when to make the application is a major one in this particular context. It can be assumed that the professionals are aware that if it is not done immediately,

there is the risk that the service user will forget about it – and it is their task to ensure that the service user obtains housing.

To conclude, the extract displays the professionals' institutional task of securing housing by giving resources, support and advice. The extract reveals how everyday decisions, like how and when to fill in the application form, can be challenging for people in vulnerable positions, and how concrete support is needed. Collaborative participation is realised by approaching the service user as a choice maker. However, the professionals express their preferences strongly as well, and in this way, they support and direct the service user's decision making. Asking questions that imply sensitivity and respect is an important discursive device to engage the service user in the discussion and strengthen his position as a self-governing participant. However, interactive activities that enhance the service user's position as a participant also comprise the risk that s/he might be directed too forcefully and in a close-ended way, potentially resulting in missing the service user's views. For all participants, participation is carried out by being involved in advice giving, decision making and choice making as well as taking a consultative and flexible stance. Emotional alignment is conducted by expressing awareness that the situation is potentially tiring for the service user, and not wanting to 'push' him to his limits. The service user aligns with these tasks by consulting the professionals and taking into account what matters to them in a particular process and shows competence in creating common knowledge (see Chapter 2 in this book).

Extract 4

Sam has recently detoxified himself from drugs and alcohol. The participants of this multi-agency meeting are Sam (S), the social worker from the outpatient clinic for drug addictions (OSW), the social worker from the outpatient clinic for alcohol addictions (ASW), the psychiatrist and the psychologist from a psychiatric outpatient clinic. Despite Sam's detox, they made a decision earlier

to continue treating Sam in the low-threshold outpatient clinic for people using drugs. Thus, the outpatient social worker asks:

1. OSW: What would you think if I booked you an appointment quite soon, or are you now in ((a hurry)), do you want to focus on finding a flat?
2. S: Yeah, I mean, that keeps me busy, but I won't be visiting ((the local housing company's office)) for, like, eight hours a day, so.
3. OSW: Be on call.
4. S: It's enough to visit there once a day; they'll call me from there, or the worker who I ((talked with)) told me that they'll call me immediately from there. I need to check that ((other local housing company)) also.
5. OSW: Could you come on Friday at 12?
6. S: Yeah, I could.
7. OSW: Yeah, I'd have an appointment for an hour there. So, we would do a concrete plan and check these ((issues)), so they are then clear to us. So that when the flat is found, it'll be possible to focus on that.
8. S: Yeah.
9. OSW: Yeah, and I'll write it down here, and it's 18th May at 12.
10. S: Yeah.
11. OSW: Okay. But I don't think there's anything unclear in this situation; now it's just the plan and other options can still be thought about, but they'll work out, one by one.
12. S: Yeah, they tend to work out.
13. ASW: One by one.
14. S: Yeah, so.
15. OSW: Yeah.
16. ASW: Do you have any questions yet about the ((outpatient clinic for alcohol addictions)), anything to do with that or other issues that you have wondered or thought about, or—?
17. S: I haven't really.
18. ASW: They'll work out.
19. S: I've visited there a few times or, well, the last time I was there was last autumn.
20. ASW: Okay.

The OSW asks Sam in a sensitive way for his opinion about booking his next appointment quite soon (turn 1). She expresses awareness and empathy about demands on Sam's time and aligns with the view that Sam may not now have the time and energy to visit the outpatient clinic for drug users. The institutional aim is to support detoxification, and this is carried out by taking into account Sam's timetable. Sam supports the idea that he is occupied with finding a flat, yet not so occupied that he

would not have time for anything else. In this way, he signals that he is willing to engage with the clinic's support (turns 2 and 4).

After Sam's positive response, the OSW is able to make a straightforward suggestion for an appointment time that Sam accepts (turns 5 and 6). A joint decision has been made. The OSW brings up that she will then have time to plan and clarify the options in Sam's current life situation together with him (turns 7 and 11). During these turns, the OSW also strengthens positive thinking: there is nothing unclear about the situation and things will work out well. By using inclusive we-terms (see Chapter 4 about the use of the 'we' term), the professional discursively aligns with the challenges and successes Sam is experiencing in sustaining his housing and life without drugs. Sam seems to confirm her reasoning and specific suggestions by using minimal responses (turns 2, 6, 8, 10 and 12).

The ASW is involved in the discussion by clarifying that if Sam has anything to ask concerning the clinic for alcohol addictions that she is available. Thus, the ASW sets herself in the position of 'customer service personnel' (turn 16). However, Sam is not in need of additional information as he does not have anything to ask (turn 17), and he has occasionally visited the service before (turn 19). Next, the ASW aligns with the other participants by sharing the OSW's positive thinking (turn 18) and accepting Sam's view (turn 20).

It is seen also in this extract that asking questions in a sensitive, empathic and respectful way is a predominant discursive device to give the service user space to express his/her views and choices. This professional-led interaction supports collaborative service user participation, yet it sets the service user in a position to give answers to pre-set questions and to make choices from pre-set options. As in Extract 3, the service user is in a central position in deciding 'when' to do the tasks that are required. Sam also decides what information is helpful for him. In this way, the service user's previous knowledge is respected and aligned with, yet it is also influenced and directed. The

professionals have a strong and leading position in negotiating the service user's access to various services. At the same time, the service user expresses competence in formulating his views and preferences. Thus, engagement requires addressing and persuading the service user's free will and decision-making power. Worth noticing is the professionals' efforts to align emotionally with the service user's reality, and how they express belief in his capability to manage future challenges. The professionals also signal that he will not be left alone, but 'we' together will ensure that things will work out.

Discussion and conclusion <2>

The aim of this chapter has been to analyse the interactional practices of collaborative service user participation. In all the extracts, participants strive for collaborative participation by aligning more or less with one another, using the various interactional devices listed below:

The service user:

- talks about his/her thoughts, and others accept this agenda (Extracts 1 and 2);
- negotiates with professionals about what would be the best course of action and timing from his/her and the institutions' points of view (Extract 3);
- holds a strong position in asking questions and setting boundaries to deal with his/her personal experiences, and others encourage this (Extract 1);
- shifts the agenda in a way that all participants agree on (Extracts 1 and 3);
- goes along with question-answer sequences and expected positioning (all extracts);
- uses constructive and expected (minimal) responses (all extracts).

The professional

- shifts the agenda in a way that all participants agree on (all extracts);
- acts as a 'teller' by constructing the service user's problems and speaking on behalf of him/her. The professional checks that the constructed reality is in line with the service user's interpretations. This involves the service user in the discussion and gives him/her the opportunity to align or misalign with the professional's views (Extracts 1 and 2);
- expresses emotional support and empathy towards the service user's troublesome experiences (all extracts);
- asks questions to give the service user the position of a decision- and choice-maker and expresses willingness to align with his/her will (Extracts 3 and 4);
- asks sensitive questions concerning the service user's strengths, yet also directs his/her decision-making by making suggestions. The professional thus displays alignment with the demands the service user is facing in the service and recovery pathways (Extracts 3 and 4);
- keeps up hope via positive utterances and thus supports and aligns with the service user's efforts (Extract 4);
- sorts out practical issues for the service user and enables him/her to engage with the services (Extracts 3 and 4).

To do collaborative service user participation requires the participants' constant reflection on interactional devices that would best enhance alignment in a given situation. Steensig (2013, p 5) makes an important point when stating, 'But pointing out what is alignment and affiliation cannot be an aim in itself. The concepts have analytical relevance only if they contribute to understanding how social cooperation (or the opposite) is done'. This has been exactly the purpose of using the analytical concept of alignment in this chapter (see also Kykyri et al, 2019).

Despite these markers of alignment and collaboration, the extracts also include turn-takings that display topic control, persuasion, passive resistance and minimal uptake. These interactional devices can be interpreted as alienation from mutual and symmetrical collaboration. They also indicate how professionals have the responsibility to lead the interaction and get on with the institutional agenda. The service user holds the power to passively resist and control his/her narration. Collaborative participation is thus always shaped and limited by institutional-professional hierarchies, various boundaries and power issues that are in play in multi-agency interactions.

It seems that questions addressed to the service user are the most common triggers for him/her to participate, but this is often done through minimal responses. This makes noticing and interpreting minimal responses an essential part of doing collaborative participation in action – they can be as critical and informative as narratives. Professionals also take a leading position and choose certain topics by asking specially formed questions. Furthermore, asking questions is a pivotal device to achieve alignment, because it indicates a willingness to give the decision-making power to the other person. Questions can comprise expressions of emotional support, empathy and togetherness, and leave space for decision-making and topic changes.

Each professional asks questions concerning topics important to him/her, and in this way, governs the particular knowledge-power domain. Questions asked by the service user reveal what is important to him/her in each situation. Recognising what matters and to whom is an important point of departure in multi-agency working towards collaboration and common knowledge (Edwards, 2017; Hopwood and Edwards, 2017). It can be concluded that the person who asks the questions is in a powerful position to direct the meeting interactions. For service user participation, an essential difference is whether the service user initiates or merely responds to questions (Peräkylä and Ruusuvuori, 2007, p 169; Matthias et al, 2012). Collaborative working requires developing interactional competencies in

multi-agency communication – developing additional 'relational expertise' that is 'a capacity to work with others to expand the object being worked on' (Hopwood and Edwards, 2017, p 108).

Accomplishing collaborative participation among people in vulnerable positions requires, as Juhila et al (2020, p 4) argue, 'strengthening clients' self-trust and capacity so that clients become gradually more confident that they have rights to present personal wishes, are allowed and able to assess their own needs and make responsible choices, and are treated by others respectfully as responsible agents' (see also Benson, 2000, p 82; McLeod and Sherwin, 2000, pp 261–2). For instance, a great number of minimal responses may imply weakness either in the service user's self-trust or in his/her position in particular sequences of interaction. Alignment can be used as an interactional device to strengthen the service user's capacity to participate. More generally, multi-agency meetings may have a role in mitigating the vulnerable position of service users in services and society, if they are constructed and experienced as integration ceremonies (see Chapter 3 in this book). Unfortunately, the data does not allow access to the participants' thoughts concerning their experiences in the multi-agency meetings – or their views on the ability of the meetings to enhance service users' integration into welfare networks and the community.

D'Agostino et al (2017, p 1248) stress that 'Provider-patient encounters are interactive and reciprocal'; thus, all participants have responsibilities in communication. Yet, it has also been argued that due to their professional skills and powerful position, professionals have greater responsibility than the service user to work towards alignment, communication and collaboration in institutional settings (Naldemirci et al, 2018). This is put into practice in our data, for instance, by being sensitive to service users' self-determination, their potentially harsh life circumstances and limited competencies to function. Challenges in everyday life and in communication challenge the ideal of an active, narrating and self-governing service user, calling for professionals' strong support in doing

collaboration. Yet, there is a risk that the greater power of professionals results in restricting the service user's ability to participate, for example, by using too fixed questions or talking too much on behalf of the client.

It has been well documented how professionals may have difficulties realising service user participation, as this requires handing over (at least partly) the decision-making power to the service user, who may have limited abilities to function (Kortteisto et al, 2018). Additionally, the service user may struggle to present his/her 'case' in multi-agency settings. There can also be situations and issues where someone is not able or willing to participate (Hickey and Kipping, 1998; Fox and Reeves, 2015; Carey, 2019; Chapter 2 in this book). In other words, collaborative working may not always be the best choice. Service user participation can also be reflected on critically as implying 'a complex form of governance and ideological control, as well as a means by which local governments and some welfare professions seek to legitimise or extend their activities' (Carey, 2019, p 1691). These critical findings demonstrate how collaborative participation is never completely but partially achieved and at risk of failing. Hence, to accomplish collaborative participation requires uncompromising critical reflection together with the active pursuit of interactional changes via discursive devices, such as alignment.

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[1] The concept has many parallel terms, such as client/patient/consumer participation/involvement (Velasco, 2001; Thomas, 2010).

[2] As Virokannas et al (2018) state, vulnerability is a contested term that is often categorised by either people's 'natural' characteristics, such as age, sex or disability, or situational aspects, such as social, economic, health and living conditions. In this chapter, the concept of vulnerability refers to the latter categorisations.

[3] Service user participation is commonly also understood in terms of individual or collective participation (Chapter 2 in this book). At the individual level, it is considered important that service users are active in setting goals, defining measurements and making choices concerning their personal service pathways (Cahill, 1996; Hickey and Kipping, 1998). At the collective level, the emphasis is on giving service users more say in planning, providing, assessing and researching services (Beresford, 2002; Carey, 2019; Chapter 2 in this book). In the text, service user participation is approached exclusively from the individual level.

[4] When studying 'naturally occurring' substance use service encounters in community settings, ethical principles such as anonymity, self-determination, voluntariness, and avoidance of harm to participants require special consideration. The research followed the guidelines of the National Advisory Board on Research Integrity, which defines ethical principles of research in the humanities and social and behavioral sciences (Finnish National Advisory Board 2020). Both professionals and service users were informed about the study and both oral and written consents were obtained.