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Responding to Clients' Descriptions of Experiential Inaccessibility in Multiprofessional Team Meetings

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Abstract

This article scrutinises clients' descriptions of experiential inaccessibility and the ways they were attended to in multiprofessional meetings that integrated clients, various professionals, and "experts by experience." The research's theoretical framework was the concept of experiential (in)accessibility and studies concerning the premises and dynamics of interactions in multiprofessional meetings. Data consisted of seven audio-recorded multiprofessional team meetings with six clients in a welfare centre located in a large Finnish city. The analytical focus was the different kinds of interactional strategies that are used when responding to clients' descriptions of experiential inaccessibility, which were related to the ways they had been treated, how they did not access the services they needed, or how they did not want the offered services because of their own or their close one's previous negative experiences or stigmatisation. Their descriptions were addressed differently through a variety of interactional strategies. They were mostly accepted by the other participants, but their experiences were also negotiated and, in some cases, bypassed or not accepted. Finally, consideration was given to whether the multiprofessional team meetings advanced the accessibility and social inclusion of the clients or whether they had become settings for further negative experiences.

Keywords

experience; inaccessibility; interaction; multiprofessional; team meetings

1. Introduction

"Accessibility" has been studied from different angles and perspectives (e.g., Grymonprez et al., 2017; Levesque et al., 2013; Raitakari et al., 2025; Vanjusov, 2022). In this article, the focus is on "experiential

accessibility," which refers to a person's experiences with services and their preconceptions related to these services (Vanjusov, 2022, pp. 181–182; Vanjusov & Ranta, 2023, p. 236). Experiential accessibility denotes the experience of being ignored or stigmatised, which can produce strong resistance towards authorities and services (Vanjusov, 2022; Vanjusov & Ranta, 2023, pp. 237–253). In this sense, accessibility is ultimately based on "issues of communication, interaction and encounter" (Raitakari et al., 2023, p. 78) and is approached in this article as a question of "experiential inaccessibility."

The background to this study is the topical issue of the social and health care reform in Finland, which involves the integration of social and healthcare services and collaboration between different professionals. Different kinds of policy trends that promote interprofessional collaboration, especially for clients with complex problems and several service needs, are intended to improve clients' participation and inclusion (Juhila et al., 2021a, 2021b; Ritala-Koskinen et al., 2025). It is thus important to study "the implementation of collaborative and integrated practice" (Juhila et al., 2021b, p. 235)—in this case, the multiprofessional meetings in a welfare centre located in a large Finnish city that were set up to develop collaborative working practices to help clients with complex problems and service needs. What happens during the interactions in the meetings is critical for shaping successful policies (Juhila et al., 2021b, p. 235) and showing how these policies are enacted (Hall & Dall, 2021, p. 43; Ritala-Koskinen et al., 2025).

The definite focus of this article is on how clients describe their (often negative) experiences, that is, the experiential inaccessibility of services, in the studied multiprofessional meetings, and how the other participants respond to them. The data consisted of seven audio-recorded multiprofessional team meetings that included six clients. They comprised various professionals working in a particular welfare centre, an expert by (lived) experience, and other professionals associated with each client's case. The clients, who had been selected and invited to the meetings, all had complex, long-term social and health problems and a history of several contacts with different social and healthcare services. The analytical focus of this study was on the interactional strategies applied by the other participants in the meetings in their responses to the clients' descriptions. For example, did they align with them, address them with understanding and empathy, or did they ignore or even deny their experiences? Studying interactional strategies from this point of view can provide insights into how to build alliances in professional encounters (Lee et al., 2019, p. 499). Focusing on the descriptions of the clients' experiences highlights their difficulties in relation to services and service encounters and provides information on how to improve such services and encounters (Vanjusov & Ranta, 2023, pp. 253–255).

This article proceeds as follows: In the next section, the concept of experiential (in)accessibility is defined in more detail, and the role of multiprofessional meeting interactions is addressed as a space in which these experiences are attended to. The data, methodology, and process of analysis are then introduced. In the results section, three illustrative extracts from the data are presented and analysed to demonstrate the different responses to clients' descriptions of experiential inaccessibility. The discussion and conclusions section includes a summary and discussion of the results in relation to earlier research as well as recommendations for interactions that support clients' participation and agency. For example, consideration is given to whether multiprofessional meetings and the interactional strategies used during them strengthened the clients' participation and inclusion or whether these meetings added to the clients' experiences of bad encounters and inaccessible services.

2. Experiential (In)Accessibility

Experiential accessibility is based on people's experiences of services, the poor reputation of services, and stigmatisation, for example, related to the use of intoxicants (Vanjusov, 2022, pp. 181–182; Vanjusov & Ranta, 2023, p. 237). It can be based on other people's opinions and perceptions of services, which can further affect an individual's perceptions of these services (Vanjusov, 2022, pp. 181–182; Vanjusov & Ranta, 2023, pp. 237, 247). In this article, the term experiential inaccessibility is used, as clients' descriptions often indicate that services and encounters are not accessible to them.

In Finland, the right to use the services without discrimination and the right to be treated appropriately are founded in social and healthcare legislation (Ministry of Social Affairs and Health of Finland, 1992, 2000; Vanjusov, 2022; Vanjusov & Ranta, 2023). Nevertheless, people who live in vulnerable situations are not always "able to ask for help because of structural barriers or shame they are experiencing" (Ranta, 2020, p. 7). It is also shown that, for example, people who use injectable drugs are fearful of negative reactions, hostile and judgmental attitudes, ignorance, accusations, and stigmatisation related to their drug use when accessing services (Neale et al., 2008; Ranta, 2020). Many individuals in European countries do not receive the benefits they are entitled to (Eurofound et al., 2015). The reasons and risk factors reported for this kind of "non-take-up of benefits" on an individual level relate to, for instance, the experience of stigmatisation (Eurofound et al., 2015). People's experiences of being treated badly and being disrespected, bypassed, underestimated, questioned, overpowered, and demoralised all inevitably cause experiential inaccessibility and people avoiding seeking help, even when they need it (Raitakari et al., 2023, p. 78; see also Maeseele et al., 2013; Ranta, 2020; Räsänen & Juhila, 2025). It has been argued that social welfare services have remained inaccessible for some groups because of their "selective" nature, which suggests that "access means only the 'right' persons and the 'right' target groups can gain access" to them (Grymonprez et al., 2017, p. 464). Access is often negotiated from the point of view of who has the right to services and benefits (e.g., Clarke, 2004; Fargion et al., 2019).

The premise behind integration and multiprofessional collaboration is to prevent clients from falling between services and to decrease the boundaries between the different service sectors (e.g., Juhila et al., 2021a). Multiprofessional work also "constitute[s] an opportunity for shared discussions that may increase both cooperation and understanding between different professionals and service users" (Juhila et al., 2021a, p. 1). Multiprofessional collaboration, which also involves the client, may prevent the "revolving door" phenomenon, which has been provided as one explanation for clients not obtaining help, e.g., from adult social work services (Juhila & Raitakari, 2024). When clients have opportunities to negotiate and define their problems (Fargion et al., 2019) and have positive experiences in service encounters, it can have a supportive and empowering effect on them (Raitakari, 2023, p. 193).

3. Responding to Clients' Experiences in Multiprofessional Interactions

Multiprofessional team meetings are one form of institutional interaction. Traditionally, the participants in institutional interactions are oriented towards their specific roles and tasks (Drew & Heritage, 1992; Drew & Sorjonen, 2011), with problem-solving as their focal activity (Ruusuvuori, 2005). This results in asymmetrical power relations between the participants and their knowledge (Drew & Heritage, 1992). In multiprofessional interactions, professionals and clients do not necessarily share the same goals (Juhila et al., 2021b, p. 226),

and professionals usually determine the topics and how the meeting proceeds (Juhila et al., 2021b; Räsänen & Juhila, 2025). Multiprofessional meetings are regarded as quite ritualised and ceremonial due to, e.g., their highly structured formats (Hall & Dall, 2021). They can take the form of "degrading ceremonies" (Garfinkel, 1956, as cited in Hall & Dall, 2021), in which clients are subjected to shaming, and their problems and perspectives are not heard (Hall & Dall, 2021; Juhila et al., 2021b). Multiprofessional interactions can thus be authority-driven, and clients may remain in marginal positions (Hitzler & Messner, 2010; Koprowska, 2021). Multiprofessional meetings can be demanding and are not suitable for all clients (e.g., Räsänen & Juhila, 2025). However, they can also be "integration ceremonies," where clients are included as active participants in discussions about their personal experience (Hall & Dall, 2021; Juhila et al., 2021b, p. 226), thereby improving the experiential accessibility. The organisational rituals and the elements of different ceremonies are momentarily constructed and negotiated in the meetings, as the participants can orient "to [a] wide range of discourses and interactional resources to manage the meeting" (Hall & Dall, 2021, p. 42).

In institutional interactions, professionals traditionally treat clients' responses as the delivery of information about their problems; thus, professionals are expected to provide task-related responses and solutions to the clients' problems (Drew & Heritage, 1992; Ruusuvuori, 2005, pp. 204–205). During institutional encounters, clients may search for not only solutions to their problems but also understanding and compassion (Ruusuvuori, 2007, p. 598). In these situations, professionals must "fit together their institutional task of resolving the patient's problem and the affective task of showing compassion and understanding to [the] patient" (Ruusuvuori, 2007, p. 598). This involves displays of empathy, namely, showing understanding and knowledge of another person's experience (Ruusuvuori, 2005, pp. 205–206) and providing affiliative responses (Raitakari et al., 2021; Ruusuvuori, 2005, 2007). These interactional practices of alignment enable cooperation between participants and provide the opportunity for client participation in multiprofessional meetings (Kalari, 2024; Raitakari et al., 2021). In everyday conversations, people perform acts of understanding in response to another person's negative experience by, for example, sharing their own similar experiences (Ruusuvuori, 2005, p. 204). These are referred to as "second stories" (Sacks, 1992, as cited in Ruusuvuori, 2005, p. 204) and are rare in institutional settings (Ruusuvuori, 2005, p. 204).

In institutional encounters, clients' expressions of their negative experiences with services or mistreatment by professionals can be considered "complaints" (e.g., Drew & Holt, 1988; Ruusuvuori et al., 2019). The professionals, as "complaint recipients" (Drew & Holt, 1988), orient to complaints differently (Ruusuvuori et al., 2019, p. 42) and may affiliate or align with a specific side (Drew & Holt, 1988, p. 408). Thus, complaints in institutional settings are co-constructed (Drew & Walker, 2009). Differences may also arise regarding who is responsible for the issue in the complaint and who is responsible for solving it (Ruusuvuori et al., 2019), as the complaints can be about an absent third party (Drew & Holt, 1988).

One way to display understanding and show clients that they are being heard is to position them as "knowers of their own experience" (Lee et al., 2019; see also Räsänen & Juhila, 2025). This recognition, known as "epistemic justice" (Fricker, 2007), implies that the client's story and knowledge of their situation are taken seriously and not overlooked. For example, as delineated in a previous paper (Räsänen & Juhila, 2025), when professionals downgrade and "soften" their proposals, they give clients epistemic rights to either refuse or accept the proposals, e.g., based on their earlier experiences and lack of trust in the services. The interactional strategies are thus manifold, and they may momentarily either demonstrate understanding and empathy for a client's experiences or they can lead to misalignment and the client's experience being bypassed (see Lee et al., 2019).

4. Aim and Data

The focus of this article is sequences in which clients describe experiential inaccessibility and how other participants (professionals and experts by experience) orient to them based on their respective roles and duties: Do they accept the client's experience or bypass it, and what kinds of interactional strategies do they employ while doing so? The research question in this study was therefore:

> How are clients' descriptions of experiential inaccessibility oriented and responded to in multiprofessional team meeting interactions?

The data were collected as part of the Integrated Work in the Renewable Health and Social Services Centre: Towards Dialogue, Participation and Spatiality project during 2021. The focus of the project was the integration of social and healthcare services from a social work perspective, as well as from the point of view of enhancing client participation. The project took place in the planning phase of the extensive reform of the Finnish social and health care system, as well as the nationwide development of social and health care centres that integrate different professionals and services (Ritala-Koskinen et al., 2025). The welfare centre referred to in this article, represents one form of social and health care centre that integrates professionals from different fields.

The data consist of seven audio-recorded multiprofessional team meetings with clients, which lasted 60–90 minutes each. The meetings were held with six clients in total (one client attended two recordings). The multiprofessional teams comprised different professionals who were working in a welfare centre: a social worker, a social advisor, a doctor, a nurse, a dental nurse, a psychiatric nurse, a physiotherapist, and a person representing third sector services. An expert by experience was present in each meeting, as was the chair who coordinated the teams. There were some variations in those who attended the meetings, as other professionals relevant to each client's case were also invited. They included professionals who had been working with the client for longer and knew their history.

The initial purpose of this multiprofessional teamwork was, for example, to assemble different professionals and the central actors related to each client's case and to find solutions for these clients' complex situations. The multiprofessional teams were so-called pilot teams which had just started to work together, and their aim was to develop multiprofessional and client-centred practices in the welfare centre (Kalari, 2024, p. 243; Räsänen & Juhila, 2025). The team meetings and their agendas were not strictly organised, and the clients had the opportunity to participate or, for example, to refuse the services and support the team was offering (Kalari, 2024; Räsänen & Juhila, 2025).

The clients' participation in the teams was voluntary. All the invited clients had long-term, complex social and health issues and histories of mental health and addiction problems. They had also had several contacts with different social and healthcare services. Some of them had faced homelessness, violent relationships, or severe somatic conditions (see Kalari, 2024, pp. 242–243). They were, or at least had been, clients of adult social work services. These clients could thus be categorised as clients who needed a lot of services (Juhila et al., 2021a, 2021b) and, as stated in the Finnish legislation, clients with specific needs (Ministry of Social Affairs and Health of Finland, 2014, § 3). They could also be characterised as clients who were found and reached (Juhila & Raitakari, 2024) and subsequently recognised as persons who need and could benefit from multiprofessional work.

5. Methodology and Process of Analysis

The analysis was based on institutional interaction studies of how participants in multiprofessional meetings orient in turn to clients' experiences of inaccessibility by using different kinds of interactional strategies (see Section 3). The meetings were understood as "joint endeavours," that is, they were created in situ: The participants views and ideas were seen as negotiated and produced during the meetings (Juhila et al., 2014, pp. 9–10). The analysis, therefore, demonstrates the ways the participants momentarily oriented to the different interactional strategies employed during the meetings (p. 13).

In the first phase of the analysis, clients' descriptions of experiential inaccessibility were coded from the data using the Atlas.ti 24 program. The codes were formed after reading the data carefully and combining these observations with the definition of experiential accessibility introduced by Heidi Vanjusov (2022). The clients' descriptions were divided into four codes: (a) experiences of being treated badly; (b) experiences of not receiving the help or services they needed; (c) stigma related to their situations, for example, to the use intoxicants, and (d) other people's views and experiences that reflect the client's own negative experiences of services. The first two themes were the most common in the data, while the other two were reported infrequently. It should be noted that two or even three of these codes could appear within one description.

In the second phase of the analysis, the responses of the members of the multiprofessional teams to these descriptions were coded into three categories, in which the description of experiential inaccessibility was (a) accepted (72), (b) negotiated (36), or (c) bypassed or not accepted (16). All these different ways of responding could appear within one sequence or at least within one meeting. No situations were found in which the client's experience was denied outright by the others.

The results of the second phase of the analysis are reported in Section 7 of this article, which includes three illustrative extracts from the data that best demonstrate the different interactional strategies applied in the meetings by the participants when responding to the clients' descriptions of experiential inaccessibility.

6. Ethics

Official permission for the research project was received from the organisations that arrange the services. Each meeting participant was informed about the purpose of the research project and the data collection. Each participant signed a written consent form and was informed that they were free to withdraw from the research at any time. Although the clients had experienced many services and negative encounters, they were nevertheless willing to participate in the data collection, as they wished their contributions to assist other people with complex and similar problems in their lives (Kalari, 2024, p. 243). One or two of the researchers attended each meeting, but they did not participate in the conversations. The data were stored and handled confidentially in line with the ethical principles of the Finnish National Board on Research Integrity TENK (2019). All the participants' names and other identifying data were removed from the extracts.

7. Responding to Clients' Descriptions of Experiential Inaccessibility

Table 1 presents the transcription symbols used throughout the extracts in this article.

Table 1. Transcription symbols.

P	Professional (+ number indicating the different speakers and their roles/professional titles)
C	Client
E	Expert by experience
((...))	Researcher's comment
(...)	Deleted or unclear speech
(1)	Pauses in seconds
—	a cut-off

7.1. Experience Is Accepted

When accepting a description of experiential inaccessibility, the members of a team display an understanding of the client's situation, give affiliative responses, and focus on the client's experience (Ruusuvuori, 2005, p. 208). The first extract demonstrates the ways a client's description of experiential inaccessibility was accepted in a multiprofessional meeting. Prior to the discussion transcribed in the extract, the client and the rest of the team had been talking about the client's somatic condition, use of intoxicants, and experiences of not being acknowledged in a substance use service she attends, and the difficulty of establishing a trustworthy relationship with the workers. Extract 1 is a continuation of this discussion, with the social worker, who was invited to the team and who knows the client's history, speaking first:

Extract 1

1. P4 (social worker): What I think stands out now and it's a very sad situation that in that ((substance use services)), that kind of personal worker relationship didn't come up, as that's the place you regularly attend to. So that'd be a clear space for it. But certainly, this is ((an issue)) that we need to think about in this group.

2. C: I was not able to speak this much ((referring to this meeting)) to that ((worker in the substance use service)), as he probably thought that I was being snappy or something, as I was so fed up. There can't be this kind of setting where I become uneasy on behalf of the nurse, as he is so young and unexperienced. So, I can't (7) we can't teach our world to anyone when someone is fishing for information. It must come some other way.

3. P4 (social worker): But then that comment about the expert by experience could be something to think about. Of course, there's also a need to find a proper common history and then to find that connection, but that could be an issue to think about.

   ((Omitted talk in which the expert by experience describes his previous experiences with finally getting help from another expert by experience))

4. P1 (chair): Good. Do you ((talks to the expert by experience)) have anything else to say about this conversation as you've been listening?

5. E: Yeah, I was thinking quite a lot about my own history, background, as there's not that much time from it. More than five years or about five years ago approximately, it was then exactly that people changed and there'd be some kind of trustworthy person also here on the professionals' side, so to say. The expert by experience really isn't, that there was always a different person, and then you tell them. I say it's very frustrating when you tell the same story from one week to another; there's always some new person and (…). That feels like the situation is not going anywhere; you're just stuck with the same shit all along.

6. C: Yes.

7. E: That there'd be so to say a trustworthy person or contact person who kind of views the big picture and takes on it. Takes the other needed pieces, ((and)) the professionals along to it and gathers your service package.

8. C: Indeed

9. E: These kinds are in many other service (…) fields that I have ran into. There's talk about the responsibility, someone in charge of a client and takes care of all issues related to it. Dunno how it can be organised in practise, but that'd be optimal ((situation))

The extract begins with the social worker's reflection on and understanding of the client's earlier description of her situation and her experience of not having a functional relationship with the worker in the substance use service, which the client regularly attends. She ends her turn by noting that this is a joint issue for consideration in the multiprofessional group. Her strategy is thus to align with the client's experience, to grasp the situation, and to try to find a solution for it together with the team. The client continues to describe the problems she faced in the substance use service that complicated the formation of a trust-based relationship with the worker. This can be interpreted as a complaint about the service she experienced and the ways she was treated there. The complaint is not addressed through action taken by the multiprofessional team; nevertheless, they take the client's side and assume responsibility to solve the problem (see Drew & Holt, 1988; Ruusuvuori et al., 2019). The social worker notes an earlier proposal to solve the situation, that is, to connect the client with an expert by experience who has shared the same experience.

A few turns have been omitted, in which the expert by experience described his similar experiences and how he finally received help from another expert by experience. Their strategy is thus to strengthen the professional's proposal to obtain help from a peer. The chair then joins the conversation and proposes the strategy of using the expert by experience as a resource by asking whether he has anything else to say in this situation. In turn 6, the expert by experience adopts the strategy of aligning with the client's story and providing justifications and evidence to the multiprofessional team that the client's experience is valid and needs to be addressed. His strategy is also to give (turns 5, 7, and 9) advice (Hall & Slembrouck, 2014) to the rest of the team on how to handle the situation: Another expert by experience is not the only solution; rather, a trustworthy, stable professional in the service field is needed—someone who will take responsibility and gather the necessary professionals. The client acknowledges these with minimal responses ("yes," "indeed").

The solution the multi-professional team arrives at is that a nurse—a member of the multiprofessional team who was absent from the meeting—will be the client's long-term contact person. The nurse will take responsibility for the situation and gather the relevant professionals and services as needed.

7.2. The Experience Is Negotiated

When negotiating a client's descriptions of experiential inaccessibility, meeting participants may not accept them verbatim but may try to negotiate them, for example, by trying to look at the experiences from another perspective. Extract 2 demonstrates how the client's experiential inaccessibility based on other people's experiences and knowledge about the service is not taken as such but is negotiated using different approaches. The problems of housing and money and the client's severe illness were on the agenda in the meeting:

Extract 2

1. P (chair): What about, as ((social worker from the adult social services)) proposed, this intermediate account service ((voluntary service where one's finances are managed by the social services)), so do you still have same view that you don't
2. C: Yes.
3. P (chair):—want it-
4. C: No, I don't.
5. P (chair):—for your assistance? It's like kind of that you'll have your own money for you to spend-
6. C: Because I know people-
7. P (chair):—just saying
8. C:—who have intermediate account service and, no, and I know their experience, so no.
9. P (chair): It's like, intermediate account service is quite mild in relation to guardianship. From intermediate account service, you'll get your own money for yourself if, for example, rent and power ((bills)) have been paid.
10. C: Well, power has never been cut in my house
11. P (chair): Yes, you've been able to handle it.
12. C: Yes (…) And my sister is, she is like, she is a guardian and like, indeed, she is a social worker in the field of alcohol ((likely a social worker in substance use services))

13. P (chair): So she also knows a lot—
14. C: She knows, she knows
15. P (chair):—about these
16. C:—so not by any means that kind of.
17. P (chair): ((asks from the expert by experience)) You haven't ever had intermediate account service, have you?
18. E: No, I haven't.
19. P (chair): As I was thinking just that, as I've had ((when working as a social worker)), these clients and many of them refused first, that no way this intermediate account service. But then, somehow, many of them, what I remember when working with clients, finally were pleased about it, as it eases the pressure of money, like handling rent or the like. But I understand the resistance well. But I have many times seen that it has helped. And then, it doesn't have to be a solution for the rest of life at all, but only for a certain time, so you'll get over the hardest crisis, especially securing housing, which is an extremely important thing. But you can think about it; maybe you can think together with ((social worker from adult social services)), as there's also this housing under question ((the client wants to move away from her current apartment as there are some problems)). Sometimes it can be that some landlords say that you can have ((the apartment)), but they require a contract of intermediate account service. But I don't know the situation, for example, with this ((refers to a company that rents apartments)).
20. C: It's like, these people have been on this intermediate account service, then they have to ask for the money, and the money comes at certain time, and they run to the ATM and so on, as there's no money, the money has not come. As I'll definitely not agree with that kind at all.

The extract begins with a discussion initiated by the chair (whose background is in social work) regarding an earlier proposal by the adult social worker (who is absent from the meeting) to introduce the intermediate account service. This indicates that the proposal is not new, and it originally came from a party that is not in attendance at the meeting. The chair asks for the client's opinion by referring to her previous comment. The client sticks to her viewpoint and refuses to take up the option of the intermediate account service. The chair adopts the strategy of persuading (see Suoninen & Jokinen, 2005) the client to use the service by explaining the intermediate account service and downplaying its seriousness (turn 9): "((It)) is quite mild in relation to guardianship." The chair seems to aim to soften the client's resistance by offering indirect advice and information about the service in question.

The client continues to refuse to take up the service, as she has second-hand knowledge and experience about it from other people who have used it. Other people's perceptions thus influence her decision not to use the service (Vanjusov, 2022). The client also provides evidence of her ability to use money (turn 10): "Power has never been cut in my house." The chair aligns with the client: "Yes, you've been able to handle it." The client

continues to justify her resistance with a reference to a family member's expertise and knowledge of the intermediate account service as inaccessible. The client has a strong viewpoint and is resistant to using the service, but the chair does not completely align with her.

The chair continues to try to persuade the client to consider the possibility of using the intermediate account service. In turn 17, the chair adopts the strategy of asking for support from the expert by experience, whose opinion the client would likely respect more, but she does not receive support from them, as they do not have any experience with the intermediate account service. The chair again speaks of her second-hand knowledge to persuade the client; she talks about her previous clients who initially did not want the service (like the client) but eventually benefited from it, as it "eases the pressure about the money, like handling the rent" (turn 19). The chair adopts the strategy of minimising the situation by explaining that there is no need for the client to use the service for the rest of her life but only to secure housing at this point (turn 19), "which is an extremely important thing." She then softens her proposal ("But you can think about it") and suggests that the client also consult the adult social worker about it. As part of her persuasion strategy, the chair shares her knowledge of the possible requirement from landlords to have the intermediate account service when renting an apartment. The client again refers to her second-hand knowledge and experience to justify her resistance to using the service (turn 20). The extract continues:

21. P (chair): What if I can still propose, as I don't know any expert by experience, who has been on intermediate account service, but if I run into one, would you be willing to talk with them? They could talk about their own experiences. I understand that there's a lot of bad experiences, but then the service has not been so (...), or whatever the reason is. But it could be, as now you have this team behind you, so we'd definitely try ((to cross)) the pitfalls, if there are any, as where does this feeling come from that this doesn't work and I have to demand my own money, so we'd try to mend it the best we can.

22. C: These people, they have been forced to fight for these issues. I trust in what they are saying.

23. P (chair): You have such strong experience with it.

24. C: Yes.

25. P (chair): But would you be willing to talk with an expert by experience if I find one?

26. C: No, I'm not. I have these experts by experience in my personal circle, and their experiences, I believe in them completely.

27. P (chair): This is something you have clearly, that you have thought about a lot and

28. C: Yes

29. P (chair): You have strong thoughts about it

30. C: Yeah, yeah.

The chair does not completely accept the client's refusal, as she continues to try to extract a small concession from the client—whether the client would be willing to talk to a person with the same experience. She also orients to align with the client's second-hand knowledge and experience but tries to convince the client that the team will be there for her and could counteract possible problems. The client again orients to experiential accessibility and refuses the offer by stating that she trusts the experience of the people she knows. The chair acknowledges this but questions the client's willingness to talk to another person who has experience. The client refuses: the service is rendered redundant because she has such people in her personal circle. The chair then recognises that the client has already considered the issue and accessed second-hand knowledge regarding the issue. The chair confirms the client's view, thereby respecting and finally aligning with her decision.

7.3. Experience Is Bypassed or Not Accepted

Although in the minority in this study, some of the participants' responses bypassed or did not reflect the clients' descriptions of experiential inaccessibility. This means that the experiences were not addressed in any way, and the participants either changed the topic or returned to discussing the issue at hand before the experience was first mentioned. The final extract demonstrates a moment in a meeting when the client's description of experiential inaccessibility was bypassed. During the meeting, the client described several experiences of underestimation and stigmatising service encounters. The meeting participants have shown an understanding of and alignment with the client's descriptions. The client's difficulty leaving his home and engaging in social activities was one item on the agenda in the meeting. The extract begins with a professional's question regarding a low-threshold coaching service that is designed to help people with out-of-home activities:

Extract 3

1. P (psychiatric nurse): You've had this Social Insurance Institute's ((low threshold coaching for young adults)), isn't that so? So how it has benefited you, how'd you assess it?

2. C: So, it was useful (…), as it helped to keep me active, but I just complained about it or cursed that in practice, when it was over, the Social Insurance Institute started to make things difficult in the final stage, as they regulated the allowances without me knowing. No one informed me that first they cut the housing allowance and then the rehabilitation allowance. No one informed me about these in advance so that I could do something about it.

   ((A few sentences omitted about an incorrect tax percentage and how the client tried to fix it and how it did not work out))

   C: I can't do business with Social Insurance Institute, as when I open my mouth, that you have a mistake there, they start to yell at me. So, I find it impossible to handle anything at all, as the treatment is like that in every area. When I tried to inform the employment office that I'm incapable of working, they started to imply that the healthcare centre knows something that I don't and that's why I need to pee in a cup. How do you react properly to things, as it's like that in every place and that's why I have started to lose my temper in every place? ((a few sentences deleted)) (3)

3. P (psychiatric nurse): That ((low threshold coaching)) has ended this year, the latest ((coaching)), hasn't it?

4. C: Yes.

5. P (psychiatric nurse): When did it end, in which month?

6. C: I don't remember (…) at the end of the summer.

7. P (psychiatric nurse): But you got out of your home with the coach (C: Yes) and was it active, ((did)) you gain that sort of encouragement?

8. C: Yeah.

The professional asks about the low threshold coaching service the client attended, including how useful it was. The client answers the question by saying that it was useful, and it helped him remain active. He then starts to describe the mistreatment he experienced when the coaching was over and the reasons he complained about them. He has had many experiences of being bypassed and is suspicious of authorities, hence descriptions of experiential and interactional inaccessibility. The client's points can be treated as a complaint, but in turn 3, neither the professional nor anyone else in the meeting orients to the client's complaint in any way (at least, this is not audible on the recording). Instead, the professional adopts the strategy of keeping to the original agenda, that is, to discuss the low threshold coaching service. As the multiprofessional team is not identified as responsible for the complaint issue, they do not, at this point, take responsibility for solving it (Ruusuvuori et al., 2019). In this moment during the meeting, the team does not orient towards dismantling the client's experiences, but rather, they maintain the institutional task of helping by trying to find a solution so that the client will have enough courage to go outside of his home.

8. Discussion and Conclusions

In the studied multiprofessional meetings, the clients identified and described a variety of experiences with different kinds of services and authorities. The clients were also given time and space to talk about their experiences, which is not always the case in multiprofessional meetings (Juhila et al., 2021b). Their experiences of inaccessibility often concerned past encounters with different authorities, which relates to the notion of interactional accessibility (Ranta & Juhila, 2025)—with accessibility being based on "issues of communication, interaction and encounter" (Raitakari et al., 2023, p. 78).

In the meetings, the clients' earlier experiences were addressed via a variety of interactional strategies; they were mostly accepted and received by the other participants, who focused on the clients' experiences and validated, were aligned with, and displayed an understanding of them. These observations connect with the notion of meetings as integration ceremonies (Hall & Dall, 2021), in which clients are oriented as active participants when discussing their personal problems (Juhila et al., 2021b, p. 226). This also relates to recognition of the client's experience and knowledge as valid (Fricker, 2007; Lee et al., 2019) and the meetings having a supportive and empowering effect on clients (Fargion et al., 2019; Raitakari, 2023, p. 193).

Notwithstanding, the clients' experiences were negotiated and not received verbatim. The other team participants used the strategies of persuasion (Suoninen & Jokinen, 2005), advice giving (Hall & Slembrouck, 2014), appeals to factual or experiential knowledge, downplaying the seriousness of the services offered, or proposals advocating for concessions from the clients to encourage them to use the services. They leveraged the other participants as resources to convince the clients to accept the proposed services because they would be beneficial for them. In particular, the experts by experience were oriented as resources to persuade the clients to accept the proposed services or to justify the clients' previous experiences. In their accounts, the experts by experience validated the clients' experiences and gave advice to the rest of the team on how to manage the situation. Most importantly, they performed acts of understanding by sharing their similar experiences, that is, second stories (Sacks, 1992, as cited in Ruusuvuori, 2005), and they provided "evidence of their ability to understand and to relate to" the clients' situations (Ruusuvuori, 2005, p. 219). The role of the experts by experience in institutional interactions is thus distinct, as their attendance is based more on being clients' peers and positioning themselves as role models who can encourage clients to change (Palukka et al., 2019, p. 33). This study thus confirms the importance of experts by experience in multiprofessional meetings, as they can build a bridge between clients and professionals, enable professionals to understand clients' experiences (Palukka et al., 2019), and strengthen clients' experiential accessibility (Vanjusov & Ranta, 2023, pp. 252, 254).

In some instances, the client's experience was bypassed; the other participants did not adopt the strategy of acknowledging the experience; rather, they challenged the experience, changed the topic under discussion, or continued with the topic that had been discussed prior to the client mentioning the experience. These moments in the meetings were similar to degradation ceremonies (Garfinkel, 1956, as cited in Hall & Dall, 2021), as they devalued the knowledge of the client (Juhila et al., 2021b, p. 236). From the client's perspective, this could have been construed as yet another experience of an inaccessible service.

When an experience was negotiated or bypassed, the professionals focused on their institutional tasks instead of the client's experience or complaint. This could be interpreted, as Raitakari et al. (2021, p. 134) noted, as displays of topic control or disconnect from the mutual collaboration, but it could also indicate the professionals' "responsibility to lead the interaction and get on with the institutional agenda." The professionals could not focus completely on the client's experience, as they needed to find a solution to the client's problem and ease their situation. Thus, the institution can set boundaries on how and the extent to which clients' negative experiences can be received (Ruusuvuori, 2005, p. 206). As shown in the respective extracts, the professionals' institutional agendas were to generate a long-term trustworthy professional–client relationship, to solve a client's housing and money issues, and to encourage a client to leave their home and engage in social activities. In this sense, the multiprofessional teams tried to improve the accessibility of the services for their clients, even though on the interactional level, they did not necessarily improve the clients' experiences of being heard and acknowledged. This is an issue that certainly needs to be studied more widely, especially from the perspectives of clients.

As this article focused on studying the multiprofessional meetings in a particular welfare centre located in a Finnish city, the results are not generalisable to all meetings and contexts, and further study of the subject is needed. Nevertheless, the analysis of the meeting interactions has made visible the various negative experiences and stigmatisation the clients or their close ones encountered and the importance of ensuring these experiences are heard, which resonates with earlier findings (e.g., Maeseele et al., 2013; Neale et al.,

2008; Ranta, 2020; Ranta & Juhila, 2025). The meetings offered a setting for the clients to describe their situations and problems and gave an opportunity to refuse the offered services based on their experiences; thus, their epistemic rights were recognised (Fricker, 2007; Lee et al., 2019; Räsänen & Juhila, 2025). As there were no strict agendas or necessity for certain decisions to be reached, it also raises a question of the team's possibilities and boundaries of helping their clients (Räsänen & Juhila, 2025). The value of this study for professionals working in multiprofessional teams is that it illustrates the importance of experiential accessibility and the necessity of building trustful encounters and interactional relationships with clients. With regard to enabling accessibility, it is essential to dismantle the obstacles and thresholds related to client encounters (Raitakari et al., 2023, p. 76). This study will hopefully help individuals who have had experiences of inaccessibility to feel they can be heard and included in social and healthcare services, especially in multiprofessional meetings.

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Conflict of Interests

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Data Availability

The data of this study is not publicly available due to ethical reasons.

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