

Interprofessional Collaboration in Swedish health and social care from a care manager's perspective: [Interprofessionell samverkan i svensk hälso- och sjukvård och social omsorg ur biståndshandläggares perspektiv]

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**Interprofessional collaboration in Swedish health and social care
from a care manager's perspective**

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Abstract

The aim of this study was to study interprofessional collaboration in health and social care for older people and persons with disabilities from a care manager's perspective. The empirical data were collected at a workshop held during a national conference for care managers and through focus group interviews in two Swedish municipalities. The results showed that the care managers collaborated in different ways with many different professionals from different organisations. The care and discharge planning meetings emerged as the most typical situation where care managers collaborated with different health care professionals. Interprofessional collaboration was seen as a means for care managers to fulfil their assignment and carry out their work. The care manager role encompassed role strain, a relatively weak professional identity, and differences in professional status among those involved in interprofessional collaboration.

Key words

interprofessional collaboration, care manager, social work, professional role, focus groups

Introduction

The complex needs of users in health and social care, together with increased professional specialisation, have led to calls for improved collaboration between the organisations and professionals involved (Axelsson & Bihari Axelsson, 2006; Bihari Axelsson & Axelsson, 2009; Glouberman & Mintzberg, 1996). Users with extensive and complex needs often come in contact with many different care-providing organisations and professional groups. In Sweden, the risks of fragmented care have been pointed out by researchers and policy-makers at different levels, who also emphasise the need for collaboration to appropriately meet care

recipients' needs (Gurner & Thorslund, 2003; Swedish Ministry of Health and Social Affairs, 2004; 2006). Issues were discussed internationally as well (Ehrlich et al., 2009; Hubbard & Themessl-Huber, 2005).

The formal goals of the Swedish welfare system are to provide universal and extensive coverage (Esping-Andersen, 1990; Swedish Government Bill 2005/06:100). Since 1992 the municipalities have had the responsibility for health and social care for older persons and persons with disabilities, including home help services and personal care, home nursing and special housing (Swedish Government Bill 1990/91:115). However, the responsibility for health care is divided between county councils/regions and municipalities and varies depending on local agreements (Edgren & Stenberg, 2006). This calls for integration and collaboration between all care providers involved, as also stated in both the Social Services Act of 2001 (SFS 2001:453) and the Health and Medical Services Act of 1982 (SFS 1982:763).

Collaboration between different professionals in front-line practice in health and social care, such as social workers, registered nurses, physiotherapists and occupational therapists, is regarded as a means to reach a comprehensive assessment of the needs of older people and persons with disabilities, leading to decisions on appropriate care and services. Yet the bases of collaboration are often contradictory. Structural barriers such as contradictory policy, legislation and rules, organisational and administrative boundaries, as well as financial issues with different budgets have been pointed out (Åhgren, 2010; Axelsson & Bihari Axelsson, 2006; Swedish National Board of Health and Welfare, 2006). Moreover, cultural barriers often obstruct collaboration. These barriers relate to differences in professional training, language and values, role ambiguity and confusion in addition to professional power and status relationships (Åhgren, 2010; Atwal, 2002; Baxter & Brumfitt, 2008; Hall, 2005; Opie 1997; Wackerhausen, 2009).

In this paper we focus on the role of care managers in interprofessional collaboration within health and social care provided to older people and persons with disabilities in Sweden. Qualified social workers, with a university degree in social work or social care, are often employed as care managers in the municipalities. They assess the individual needs of older people and persons with disabilities and decide what type of social care and which services will be given within the confines of prevailing policy and available resources (Dunér & Nordström, 2006; Wolmesjö, 2005). The care managers reach their decisions independently, on delegation directly from the municipal board of social welfare. In Sweden, the role of the care managers have been a topic for intense debate since late 1990's, in connection with the introduction of New Public Management in social care of older people and persons with disabilities (Blomberg, 2004; Wolmesjö, 2005).

However, social work for older people and persons with disabilities is quite marginalised within the Swedish social work context, including both the practical development and research within the field (Melin Emilsson, 2013). Often, it is labelled 'social care' and is not considered to be at the core of social work practice (Johansson, 2008; Melin Emilsson, 2013). The administrative focus, and the fact that the work is carried out in close collaboration with the health care system and health care professionals, imposes challenges to care managers in social care of older people and persons with disabilities (Lumberly et al., 2007; Melin Emilsson, 2013; Phillips & Waterson, 2002; Postle, 2002; Wolmesjö 2005).

The care managers' roles differ from the traditional roles for social workers. The main activities of care managers are making short-term assessments and planning care (Lumberly et al., 2007). In the UK context, care managers' work has been defined as 'including assessment of a person's needs, arranging care to meet those needs and monitoring

and reviewing care' (Postle, 2002, p. 336), a definition roughly corresponding to that of care managers' work in Sweden as well.

Aims and research questions

The aim of this study is to examine interprofessional collaboration in health and social care for older people and persons with disabilities from a care manager's perspective. Initially, we explored the setting of the collaboration. This was followed by a more focused analysis of the objective and function of interprofessional collaboration, and the care manager's role in this collaboration. Specific research questions are:

- How do care managers view the objective and function of interprofessional collaboration?
- How is the care manager's professional role experienced and what expectations do care managers perceive their collaborators to have of them?
- How can interprofessional collaboration be understood in terms of identity, status and discretion of the professionals involved?

Conceptual framework

Identity, status and discretion

Professions may be seen as primarily self-interested groupings, and consequently interprofessional rivalries may negatively affect collaboration. Hudson (2002) identifies three core areas where such rivalries are played out: professional identity, professional status and professional discretion. Professional *identity* determines who will be included or excluded within a professional group and it also sets the boundaries towards other professions (Payne,

2000). Identity through the possession of specific knowledge is a vital part of professional identity (Hudson, 2002). As there are no formal educational requirements¹ for work with care assessment and management in Sweden, persons from various educational and professional backgrounds influence care managers' professional development (Wolmesjö, 2008; Wolmesjö & Richard, 2011). Most care managers, however, have a bachelor's degree in social work or social care. Social work degree courses provide general education. After their exam, students work in many different areas of social work. Informal processes therefore also shape the professional identity of the care managers when they are socialised into the "practice wisdom" of the profession (Hudson, 2002; Thompson, 1995). This, in turn, can make it more relevant to talk about "different professions in the profession" rather than viewing social workers as "one" profession (Abbott, 1988). In interprofessional collaboration, the care managers as well as the other professionals will take and be given different role identities. When members of a profession have a strong professional identity, there will be more agreement within a profession than between two different professions (Hudson, 2002).

Professional *status* concerns the hierarchy of professions and the division into full and semi-professions (Evetts, 2006; Hudson, 2002). In health and social care, the professions differ with regard to the length of formal training, societal authorisation and the right to practise, all matters shaping their professional status. Therefore, lack of a common knowledge base, training and autonomy may inhibit care managers' and many other social workers' recognition as full professions (Evetts, 2006; Wolmesjö, 2008). Different logics creating and maintaining professional status may be distinguished. Occupational professionalism, based upon trust in the professionals' education and ethics and organisational professionalism and authority, is built upon the professionals' position in the organisation and

¹ The Swedish National Board of Social Welfare have published a list of recommended skills and knowledge for work with older people (SOSFS 2007:17) and persons with disabilities (SOSFS 2008:32).

the relevant regulations and routines (Evetts, 2006). Interprofessional work is often positively affected when members have similar professional status (Hudson, 2002).

The diversity and lack of definition in care managers', and also other health and social care professionals', professional work, together with the fact that each case needs to be individually assessed, makes professional *discretion* necessary (Evans & Harris, 2004; Hudson, 2002; Lipsky, 1980). The scope of the care managers' and other social workers' discretion and professional autonomy has previously been discussed (Wolmesjö, 2008). As governing documents and guidelines from municipal management and boards are becoming more detailed, the care manager's role may become more administrative and less independent. Furthermore, care managers need to handle different, often contradictory, demands related both to individual needs and limited economic resources (Lipsky, 1980; Wolmesjö, 2005), a situation that may cause tensions and role strain. Working interprofessionally may be less attractive to some, if it is perceived as threatening established assumptions of how professional discretion should be applied (Hudson, 2002).

Interprofessional collaboration

According to Axelsson & Bihari Axelsson (2006), collaboration is defined as a form of integration between professionals at the same organisational level. Collaboration is thus based on voluntary agreements, mutual adjustment and the willingness to collaborate. Organisations, and the professionals involved, collaborate in their day-to-day contacts and communication (Axelsson & Bihari Axelsson, 2006). Professional roles are shaped by internal as well as external expectations. The prefix 'inter' in 'interprofessional collaboration' implies that 'professional groups make adaptations in their role to take account of and interact with the roles of others' (Payne, 2000:9). Professional groups may collaborate both within an organisation (intra-organisational collaboration) and between different organisations (inter-organisational collaboration). In this context, role strain may appear when the internal

expectations within a professional group diverge from the expectations of their external collaborators. Furthermore, additional role strain may occur when there are differences in the external expectations. Interprofessional collaboration is needed since the organisations involved are wholes with subsystems, which are interdependent of each other and need to collaborate (Loxley, 1997; Payne, 2000). The professionals are expected to get involved and contribute something to the collaboration since they will receive something in return that they need, or at least that is the assumption. Moreover, the outcome of collaboration is expected to be better results (Axelrod, 1984; Payne, 2000).

Interprofessional collaboration often takes place in teams. Payne (2000) points out three paradoxes in interprofessional teamwork. First, there is the risk of becoming inward-looking while concentrating on building relationships within the team, when needing to look outward to other professions or agencies. Second, the team can be too close and united against outside pressure, both limiting the professional freedom and threatening the possibility to carry out the organisation's objectives. Third, being too team-focused may negatively affect the care recipients' right to influence the team's decision-making.

Methodology

The design of this exploratory study was developed in collaboration with care managers participating at an annual national conference in 2010. The care managers were invited to take part in a workshop aimed at initiating a new research project. Issues raised at the workshop were followed up in two focus groups in two municipalities chosen by size of population and geographical location in southern Sweden. The participants in the focus groups were recruited independently, and only some of them participated in the workshop. One municipality had fewer than 130 000 inhabitants, the other had nearly 500 000 inhabitants. Correspondingly, we called the two focus groups the 'smaller' (S1 and 2) and the 'larger city group' (L1 and 2).

According to Swedish law no ethical permission was needed (2003:460). Participation was voluntary, and oral, as well as written informed consent, was collected from all participants at the study start.

The *workshop* had 40 participants, 38 women and 2 men. Most of the participants were care managers in municipal social care of older people and persons with disabilities or worked at municipal research and development units. Altogether, they represented 19 municipalities. The workshop focused on the settings of interprofessional collaboration, challenges and possibilities, the care manager's role, and ethical dilemmas in interprofessional collaboration. The aim was to identify important issues to gain new knowledge about and to map the setting where care managers participate in interprofessional collaboration. Working in small groups, participants brainstormed the issues. The results of the groups' brainstorming sessions were then presented in visual form to all participants, who were invited to confirm or argue against the points made and/or add new items. Further to this, a key point or thought was collected from each participant and jotted down on flipcharts in a brief summarising session, during which the speed and activity were high and 'the views of 40 persons were received in 40 minutes'.

Eighteen care managers, 16 women and 2 men, six from the 'smaller city group' and twelve from the 'larger city group', participated in the *focus groups*. They were recruited through administrative managers of each municipality. Participants were between 27 and 62 years old, had a university degree in either social care or social work, and had worked as care managers for between one and 30 years. The focus group participants were therefore a fairly homogeneous professional group (Brown, 1999; Robson, 2002). The focus groups met twice, and the discussion concentrated around topics initiated at the workshop. The facilitator structured the discussion by focusing different situations, challenges and possibilities, and the care manager role in interprofessional collaboration. A dual moderator technique was used,

where one researcher ensured that the session progressed smoothly, while the other made sure all the topics were covered. Discussions were audiotaped and transcribed verbatim.

The mapping from the workshop was summarised in a descriptive approach. The analysis of the qualitative focus group interviews took an empirical point of departure and proceeded from open to focused coding in several steps (Emerson et al., 1995; Silverman, 1993). Our analysis and interpretation of the empirical findings were guided by the theoretical concepts and previous research. In the first step we took an empirically oriented approach, and the transcripts were read through several times by both authors and preliminary empirical themes were identified. In the second step, the empirical themes relevant to our research questions were chosen and presented. Quotations were used to illustrate the resulting themes. The results were later interpreted and discussed according to our conceptual framework and earlier research. Results from the workshop and the subsequent focus groups were presented and discussed at a seminar at the same national conference for care managers 1 year later. Almost 40 new participants took part in the seminar and confirmed and recognised the results, thus providing member validation (Kvale & Brinkmann, 2009).

Interprofessional collaboration from a care manager's perspective

The settings

The settings for the care managers' interprofessional collaboration are described according to results from workshop as well as from focus groups.

Where?

Care managers at the workshop described that they participate in interprofessional collaboration in many different arenas. The collaboration takes place in care planning or discharge planning conferences at hospital wards, at home visits and in team meetings in the municipality. The care planning situation emerged as the most common form of collaboration. One focus group participant from the larger city described it as follows: ‘I feel it is this situation that can make my job really hard and difficult and also very fun when it works, and it is by no means a focal point that is very important.’ (L1).

With whom?

At the workshop, it was shown that the care managers most often collaborated with different health care professionals, such as registered nurses, occupational therapists, physiotherapists and nursing assistants from hospitals and primary and municipal health care. One of the focus group participants related, ‘I work with social care in many different areas. It can be with parents who have a disability or it can be social problems ...’ (L1). This range of work makes collaboration with a wide range of other professionals in many different organisations necessary. A long list of agencies and professionals was drawn up at the workshop and included municipal managers of health and social care units, managers of family social care units, personal assistants, home help personnel, dementia teams and controllers, as well as professionals from other organisations, public as well as non-governmental, such as trustees, police, lawyers, cleaning companies, churches, landlords, and staff from the county council administration, pensioners’ organisations, transportation services, insurance companies and rehabilitation centres.

About what?

Care managers, in both the focus groups and the workshop, described they focused on needs assessment, where they collaborated with other professionals to investigate the needs and daily life of the care recipients. Issues included whether home care or special housing was required to meet the individual's needs. Other issues were administrative, such as procedures for discharge from hospital, municipal liability to the county council for hospital care, information about the care management process, and fees for care and services.

How?

The results from both workshop and focus groups established that care managers collaborate through oral and written communication. As mentioned above, the daily work of care managers includes care planning meetings where they interact face to face with other professionals. In addition, they communicate with others via telephone, mail, fax, video, and text messages.

Interprofessional collaboration – objective and function

The objective and function of the care managers' interprofessional collaboration is analysed below according to the results of the focus groups.

Strive in the same direction to fulfil the assignment

In the focus groups, the care managers emphasised that they were dependent upon collaboration with other professional groups within their own organisation as well as other organisations to fulfil their assignment towards the care recipients. They also mentioned the legal demands for collaboration, in both the social and health care legislations: 'Collaboration is stated in both the Health and Medical Services Act and the Social Services Act; there are demands from both directions' (S1).

Interprofessional collaboration, according to the participants, means that different professionals need to strive for common goals, such as respecting the personal wishes of the care recipients or striving to perform as much care as possible in their home rather than in special housing. Top management has the important task of setting the goals and defining the direction of the work. Thus, collaboration at the strategic level is essential for smooth collaboration at the operative level. The care managers felt that it is essential ‘... that we in the municipality keep together and work for the same values’ (L2) and that ‘... we’re supposed to have the same goal in the municipality, we should have that. But we do not have that, I think’ (L1).

In the focus groups there was consensus about what characterises a good working collaboration. When all involved parties show their willingness and effort to collaborate and strive in the same direction, collaboration may be easy and run smoothly. The care managers described collaboration as a give and a take, and as something that the collaborators have to continuously work on to keep it alive.

However, the participants mention that conflicting goals of the organisations involved and the prioritising of the goals of one’s own organisation or profession may obstruct interprofessional collaboration. Professionals from the different organisations strive to keep the budgets of their own organisation balanced. Consequently, they tend to interpret issues differently in order to avoid responsibility or costs: ‘When a problem occurs, you push it over to one another, like, ‘This is a medical issue which you have to take.’ – ‘No, it’s social’ (S1). While this can happen, collaboration with other professionals is not, per se, perceived as problematic:

What is strange is when we look across the table and wonder, who is going to take the responsibility [the registered nurse and the county council or the care manager and the municipality] – then we seem to forget about the person in focus. (S1)

Lack of time and stressful working conditions often force those involved to prioritise the work of their own organisation and this has a negative effect on collaboration. An often mentioned example from the focus groups was when the care planning meetings were badly planned and the ward nurse had not met the care recipient prior to the meeting or did not know his or her current situation. As one participant said, ‘Today, all professionals live with a high stress factor, keeping up with what you should do, and this leads to difficulties in planning’ (S1).

Bridging between organisations and professions

Insufficient knowledge about each other may hinder collaboration. Accordingly, one function of interprofessional collaboration, which was emphasised in the focus group discussions, was bridging between organisations, organisational units and professions involved in the care of older people or persons with disabilities. One role of some professionals is to function as link between the different organisations, the municipal services and the hospital. Examples from the focus groups are the nurses from home nursing and municipal dementia nurses, since they can talk to their colleagues at the hospital in a way that they can relate to and still strive for the goals of municipal health and social care together with the care managers:

We always have a nurse from home nursing with us [at the care planning at the hospital]. It feels safe ... she can push back and say, ‘He isn’t ready for discharge, he needs this and this before’.

(L2)

Furthermore, the participants expressed that the nurse can be trusted to explain what the municipal health care can provide: ‘They [nurses from home nursing] usually say that ‘If only we had a picture hook to hang the dropper bottle on, there would be no problem, then we could solve it [provide care] at home’ (L1).

It emerged in the focus groups that appointing certain professionals whose main chore is to collaborate, such as care planning coordinators both in the municipality and in the hospital, is a way of facilitating collaboration between the organisations. These people are often very well aware of the different conditions, possibilities and difficulties at hand.

However, the different educational backgrounds of the different professional groups imply different views on the problems, needs and solutions. Differences in profession-specific traditions and/or ethical values may cause conflict and tensions among those involved, which are not always possible to overcome. For example, the care managers in the focus groups raised the issue that nurses, in both municipal and hospital settings, put their own expert assessments over the wishes of the care recipients. Sometimes, these conflicts between professionals are played out in front of the care recipients:

... a home visit. Then, it was almost a conflict at home. // This, I feel, it is so unprofessional to take such a discussion, in [a care recipient's] home when we both know what we can do. (S1)

Yet, the care managers pointed out that persons with different positions and functions may have different approaches even if they share the same educational background: 'they [the home help managers] look at their budgets ... then she [the care recipient] needs help with personal care, getting dressed and so on, while the manager urges the care personnel to hurry up' (L2).

To work together in teams may bridge the gap between different professionals within the municipality, according to the participants in the focus groups. They also expressed that if different professional groups worked together in teams rather than in separate units, they may learn from each other and it may also be easier for them to strive together for the goals of the municipality.

Additionally, the different conditions for the different professional groups, in terms of how often or for how long they interact with the care recipients, affect how the care recipients weigh the views and assessments of the professionals, i.e. they affect the status they give the professionals. In most cases, the care managers in the focus groups meet the care recipients on one or a few occasions, and for a short time. They mention that nurses, the occupational therapist and the physiotherapist and especially nurse assistants, often meet them more often, during longer times. This makes the care recipient keen to listen more to the assessments of the latter, causing tensions between the care managers and the other professionals:

I understand if they trust a doctor or a nurse more, they have been at the hospital ward maybe 3 or 4 weeks and met the health care personnel every day... then we come and meet with them for half an hour, for the first time. (L2)

However, some of the care managers felt that this gave them the opportunity to objectively focus on the rights of the individual as representatives of the public power. 'It is complicated; everyone has equal rights but it does not mean they should have the same. It is our role to investigate the needs and it often goes well' (S2).

The care manager's role in interprofessional collaboration

The care managers' own views

At the workshop, the care managers identified a wide array of, often conflicting, roles that they needed to adopt in interprofessional collaboration, including the roles of:

- *Coordinator* – to coordinate and participate in the collaboration process
- *Need assessor* – to investigate and assess needs and make decisions
- *Representative of public social care* – to inform and control
- *Boundary setter* – to identify the scope of municipal social care’s responsibility and involve other professionals and organisations
- *Counsellor* – to mediate and give support and social care
- *Record-taker* – to report statistics and register cases.

In the focus group discussions, the care managers described their role of providing the care recipients’ first contact with the municipal authorities as important. Their role was to initiate and coordinate contact with the appropriate professionals and care providers within the municipality, such as home help services, home nursing and rehabilitation. ‘The care manager’s role is a powerful position, it really is ... you need to be aware of what our role means to many older people’ (S1). Moreover, to gain all the information required and know what services to offer, care managers need to have a wide range of knowledge in many different areas of the welfare system. This involves knowledge of the responsibilities of different agencies and the specific skills of different professionals. ‘As a group we have substantial knowledge of who you can take up contact with, where you can turn to’ (S2).

Most of the participants in the focus groups believed that their role also involved negotiating with the municipal management to take appropriate measures according to the needs of the care recipients. The arguments that were most successful in these negotiations were those concerning economic effectiveness. However, some strategic decisions were made “above their heads” and negatively affected collaboration. ‘If you don’t have the resources, it is difficult to have a good collaboration with the hospitals’ (L2). As mentioned previously,

compared with other professionals with whom they collaborate, care managers usually only have short, occasional contact with the care recipients. Another difference that was stressed in the focus groups is that, compared with the professionals in the hospitals, the care manager's responsibility stretches on for long periods. Care managers, and the municipal care and services, have to see to proper arrangements so that the care recipients can manage their daily lives for the rest of their lives.

The participating care managers viewed their professional status as linked to the power associated with their position in the organisation, and their right to decide upon which care and services would be granted the care recipients. This was different from some of the professional groups with whom they collaborated, such as physicians and registered nurses whose power was rooted in their professional status or professional knowledge:

but the classic situation is the physician, who is God in many older people's eyes. If you reject an application, they say, 'Then I will tell the doctor, he will give you a call and he will arrange it.' – This brings it to the head in a way, I think, ... since he or she [the physician] is not in authority to take the decision of special housing or short-term housing. (S1)

Role expectations

Overall, the care managers in the focus groups believed that they were expected to take charge of the situation and coordinate those involved in the collaboration. 'When we arrive we're expected to take charge of all contacts' (S2).

Furthermore, they mentioned many, often conflicting expectations from their collaborators, both from their own municipal management and from other professional groups in their own organisation as well as other organisations, and from the service recipients and

their next of kin. Often, they felt, these expectations arose because others lacked knowledge about their professional role and about who makes the decisions about care and services.

Many examples were given in the focus group discussions, such as expectations of loyalty from the politicians and management in the municipality at the same time as others expected them to make decisions on care and services that were contrary to municipal guidelines. The care managers felt that they were sometimes pushed into taking on a role of formal, bureaucratic and cold-hearted person in authority:

the home nursing [the nurse] can tell me, “Don’t come dragging in that law again” when you explain why a person’s application will be denied. – I get the feeling they think of us as hard when we, contrary to the nurses, think about economy as well, avoiding liability for hospital care and that. // We are perceived as the wicked witch and they [the nurses] are the fairy godmother.

(L2)

At other times, care managers expressed that they are caught between the care recipients’ views of their needs and the views of other professionals, and have to support the care recipients’ right of self-determination:

You enter a meeting with the district nurse. What expectations they have from us. The first thing she used to say is: “Here comes the woman in charge. ...”

[Facilitator: Are you the one in charge?]

No, I don’t think so, I can do my part but I can’t take over the person’s life. The Social Service

Act is voluntary, I try to explain that. (S1)

Discussion and conclusions

The results of this study confirms findings from other studies, where the complex needs of the care recipients, and the professional and organisational specialisation lead to the need for many different actors to be involved in the care management process (Axelsson & Bihari

Axelsson, 2006; Ehrlich et al., 2009; Glouberman & Mintzberg, 1996). One specific situation emerges as the focus of care managers' interprofessional collaboration: the care planning or discharge planning meetings. Here, the care managers mostly collaborate with different health care professionals, in face-to-face interaction.

The care managers in this study perceived interprofessional collaboration as a means for them to fulfil their assignment and carry out their work. They regarded themselves as dependent on other professionals both within their own municipal organisation and from organisations in the county council, i.e. hospitals and primary care (Loxley, 1997; Payne, 2000). The care managers emphasised the importance of facilitating and taking part in interprofessional collaboration if the collaboration will lead to better results, both for the care recipients and for the professionals and organisations involved (Axelrod, 1984; Payne, 2000).

Interprofessional teams were seen as a way to improve collaboration between different professionals from different municipal units. However, it has been argued that participants' focus on common municipal goals to unite against outside pressure may hamper collaboration with professionals in other agencies (Payne, 2000). Furthermore, interprofessional collaboration, especially in teams, may endanger the influence of the care recipients (Berglund et al., 2012; Payne, 2000; Wolmesjö 2005; 2012). This suggests that the professionals involved in collaboration may "forget" the care recipients' own view as they focus entirely on issues of professional and organisational accountability. Similar results were found in a study of collaborative processes between child and youth psychiatry, social services, schools and families (Blomqvist, 2012).

This study raises the question whether it is possible to talk about social care managers as a specific profession and describe *one* common role (Abbot, 1988; Hudson, 2002; Payne, 2000): 'The complex role is what makes it specific' (S2). The results point to the care manager role in interprofessional collaboration, as encompassing many different

roles. Some roles, such as that of coordinator, representative of public social care, boundary setter, and record-taker, are in line with the administrative focus of care management (Melin Emilsson, 2013; Postle, 2002). Other roles, above all the role as counsellor but possibly also the needs assessor role, are more in line with more traditional social work (Melin Emilsson, 2013; Phillips & Waterson, 2002; Wolmesjö, 2005).

Furthermore, the results suggest that care managers may experience a role strain. On the one hand, they often have to support the wishes of the care recipients and make sure they are included in the care planning process. On the other hand, they are expected to represent the interests of the municipal authorities and turn down applications for care and services beyond the scope of the municipal guidelines (Dunér & Nordström, 2006).

Moreover, the study reveals a clash of cultures between care managers' administrative focus and health professionals' focus on expert knowledge. This illuminates the cultural barriers also shown in other studies, which may obstruct interprofessional collaboration (Åhgren, 2010; Atwal, 2002; Baxter & Brumfitt, 2008; Hall, 2005; Wackerhausen, 2009).

This study shows the care managers' difficulties in defining and expressing their professional knowledge, a fundamental part of a professional identity (Hudson, 2002). Their knowledge about national laws and municipal guidelines, together with general knowledge on the welfare system, seems to constitute the core of their professional knowledge. This may be interpreted as a fairly broad and general professional competence, possible to obtain through education at different levels. As mentioned, no specific educational background is required for care managers, which may challenge claims for professional status and jurisdiction (Abbott, 1988; Wolmesjö, 2008; Wolmesjö & Richard, 2011). Moreover, the care managers in this study drew attention to professional differences between them and, for example, health care professionals, stemming from differences in educational background. At the same time

they described differences between themselves as care managers, and individuals in other positions within the municipality who shared the same professional and educational social work background. Hence, informal processes and socialisation into the practice field affected their professional identity (Hudson, 2002; Thompson, 1995). Care managers' professional identity as well as their identity as social workers may therefore be characterised as fairly weak (Hudson, 2002).

The results point to differences in professional status and existing professional hierarchies among those involved in interprofessional collaboration in health and social care. Such differences in power may render collaboration more difficult (Hudson, 2002; Payne, 2000). Health care professionals, above all doctors and nurses, enjoy a higher professional status, rooted in their education and ethics, i.e. occupational professionalism (Evetts, 2006; Liljegren, 2012). The care managers' professional status is, on the other hand, based on their position in the municipal organisation, where they have the authority to decide which care and services will be granted the care recipients. This may be understood as organisational professionalism (Evetts, 2006). Problems often arise when other professionals make promises to the care recipients, which they do not have the formal right to decide about. A clash between different rationalities appears, i.e. between the formal rights of the care manager on the one hand, and the status of and trust in the knowledge of health care professionals on the other. Issues concerning professional authority, accountability and discretion may render interprofessional work less attractive to those at risk of losing well-established professional authority and status (Hudson, 2002). Our results show that care managers' professional authority and discretion, based on delegation from the municipal board, are sometimes threatened from within the organisation as well, since some decisions are formally made by top management or by detailed municipal guidelines (Dunér & Nordström, 2006; Evans & Harris, 2004; Lipsky 1980; Wolmesjö, 2005). Hence, in intra-organisational collaboration,

care managers have to handle and mark boundaries with both the management level and other professionals at the operative level within the municipal organisation. At the same time, they have to collaborate inter-organisationally and interprofessionally with their external partners, at the operational level.

This study is a rather small-scale exploratory piece of work, and we do not know how generalizable the findings are. Furthermore, the questioning of the role of the care managers in Sweden may have influenced the results' focus on problems and negative experiences of the care managers' interprofessional collaboration.

The result of this study shows that the conditions for the care managers' collaboration with other professionals are affected by power relations, as well as perceived role strain. The professional status of the professionals involved, shapes the power relations between them. The care managers experience their own professional status as being low, whereas the health professionals, that is, doctors and nurses, enjoy a higher professional status rooted in occupational professionalism and expert knowledge. These differences in professional status and power make collaboration more difficult from the care managers' perspective. The participating care managers experience role strain, as they have to take a variety of conflicting interests into account. They have to balance between monitoring the interests of both the care recipient and the organisation, while they also want to protect their own professional authority. As the care managers' professional status is dependent upon their position in the organisation, they are probably more exposed to role strain than other professionals, with whom they collaborate, who have a more independent professional authority. However, further research is needed to shed light on the experiences of other professional groups with whom care managers collaborate. Moreover, further research is needed on the care recipients' perspective and roles in interprofessional collaboration.

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