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Published in:
Nordic Social Work Research

DOI (link to publication from Publisher):
[10.1080/2156857X.2018.1518818](https://doi.org/10.1080/2156857X.2018.1518818)

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Publication date:
2020

Document Version
Accepted author manuscript, peer reviewed version

[Link to publication from Aalborg University](#)

Citation for published version (APA):
Dall, T. (2020). Distribution of responsibility in inter-professional teams in welfare-to-work. *Nordic Social Work Research*, 10(1), 80-93. <https://doi.org/10.1080/2156857X.2018.1518818>

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Distribution of responsibility in inter-professional teams in welfare-to-work

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This is an Accepted Manuscript of an article published by Taylor & Francis in Nordic

Social Work Research on 13 September 2018, available online:

<http://www.tandfonline.com/10.1080/2156857X.2018.1518818>

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Welfare-to-work has imposed constraints on professional social work, yet research into the exercise of professional responsibility in public welfare settings has paid limited attention to the organizational context of professionals. This article examines how professionals define their responsibilities and how they shift certain aspects of their decision making responsibilities within the team and in the organization of the Jobcentre. A discourse analysis of 19 interviews with team members in Danish rehabilitation teams found three different ways of managing tensions between different features of institutional and professional responsibilities: deferring responsibility to the legislation, emphasizing the importance of inter-professional team work, and emphasizing the professional responsibility of individuals. These empirical findings are discussed in relation to Bauman's theory on division of work and displacement of responsibility. This paper concludes that, while considerable organizational mechanisms are at play that displace moral and professional responsibility, professionals seek to manage these challenges in (inter-)professionally responsible ways.

Keywords: professional responsibility; welfare-to-work; accounts; inter-professional team

Introduction

The introduction of welfare-to-work policies has placed labour-market participation at the forefront of social welfare services in the Nordic and wider European countries, and has included increasingly more vulnerable individuals as part of the target group for these policies (van Berkel et al. 2017). Labour-market participation is thus not reserved for unemployed people with no other challenges than unemployment, but is increasingly seen as a means of ensuring social integration and individual welfare for people with social problems besides unemployment (Møller and Stone 2013, Lindsay and Houston 2013). The inclusion of clients with complex challenges under welfare-to-work efforts and the concurrent specialization of services (Grell, Ahmadi, and Blom 2016; Raeymaeckers 2016) have necessitated collaboration across different sectors, as well as a focus on 'holistic' and coordinated interventions (Axelsson and Bihari Axelsson 2006; Røysum 2013).

The rehabilitation teams studied here provide one example of these developments. The teams are established with the aim of making holistic assessments and recommendations for clients with complex problems in addition to unemployment. By bringing together professionals from social, health, and employment services, the aim is to ensure coordinated interventions across specialized sectors. This is to take place within the context of welfare-to-work policies with labour-market participation as the end goal. In many ways, then, professionals from social and health services are enlisted as part of the effort to bring clients with complex problems into work. This simultaneously introduces new responsibilities for professionals who are otherwise not part of the employment services, and shifts responsibilities between professionals within the employment services.

Organizational changes are often done with reference to improving efficiency, accountability, and, in this case, coordination and quality of work, yet they also change

who does what, how, and under which conditions (Brodkin 2013, 25-26; Larsen 2013) and do, thus, directly influence professional work. As the literature on street-level bureaucracies has effectively shown (Lipsky 1980/2010; Brodkin and Marston 2013), what welfare-to-work and the organization of decision making means for professional responsibilities and practices must be studied at the street level itself.

This article examines how responsibility is distributed in inter-professional rehabilitation teams, from the perspective of the professionals themselves. Specifically, this paper examines how professionals define their responsibilities and how they shift certain aspects of their decision making responsibilities within the team and in the organization of the Jobcentre. While the rehabilitation teams are a specific Danish introduction, the teams are exemplary of wider tendencies in the Nordic countries in which coordinated, holistic services (Røysum 2013) are emphasized alongside the imperative of labour-market participation (Jacobsson, Hollertz, and Garsten 2017).

This article will contextualize the rehabilitation teams, before discussing empirical and theoretical approaches to the study of professional responsibility in institutional settings. It then presents the data, methodology, and findings of the study, before discussing these findings in relation to the research question.

The introduction of rehabilitation teams as part of Danish employment services

The rehabilitation teams were introduced in 2012 as part of extensive reforms of the Danish employment services. The overall aim of reforms was to bring more people into work and reduce the number of people on public benefits, such as disability pension. This was to be achieved through stricter conditionality for receiving benefits, lowering the level of benefits, and increasing demands of activation while receiving benefits. For clients with problems in addition to unemployment, these measures were to be

accompanied by coordinated, personalized, and holistic interventions (Caswell, Dall, and Madsen 2015).

Within these movements, the rehabilitation teams were introduced. All municipalities have to form a rehabilitation team consisting of representatives from municipal health services (in our data, a physiotherapist, occupational therapist, or nurse), social services (social worker or social pedagogue), employment services (social worker or social administrator), and the medical region (medical doctor). These teams are to make assessments and recommendations in all cases moving toward disability pension, flexible employment, and resource programmes. Legislation states that assessments have to take account of ‘the whole situation of the client’, and recommendations must be oriented towards efforts that can ensure the labour-market participation of the client (“Bekendtgørelse af lov” 2014, §9 stk. 3). The client is obligated to attend the meetings, as client participation was a stated aim when the teams were introduced.

According to law, the recommendation must concern both which benefit is appropriate for the client and which interventions the team can suggest for improving work ability. In terms of benefits, decisions are made around four possible outcomes: recommendation for disability pension, flexible employment, resource programme, or return to ordinary interventions of the employment services. Eligibility for either benefit is defined in various parts of the legislation. In terms of interventions, these are, to some extent, related to the given benefit, as interventions within the remit of the employment services (e.g., work placement) depend on the benefit of the client. The interventions pertaining to the other departments present (e.g., physical rehabilitation or home care) are tied to eligibility, according the legislations and guidelines of these respective organizations. Overall, various resources are defined in legislation, but these are also

determined by the local conditions of available programmes and interventions. The team members are seen as equal participants in the decision making process, but, as will be demonstrated below, the legal structuring of team recommendations means that the representatives from employment services will often have a decisive role, as they have the most detailed knowledge of the legislation in this area.

The introduction of the rehabilitation teams has split the granting of benefits into tasks of describing the client, recommending interventions, and deciding on eligibility, organized under the responsibility of three separate actors. Case workers within the employment services will prepare a case for the rehabilitation team, which will then make a recommendation and send the case to the relevant granting body, depending on the recommendation. Different boards or individuals then have the formal authority to decide whether a client is eligible for the benefit and intervention that the rehabilitation team has recommended.

Previous work on the distribution of responsibility in public welfare institutions

The following discussion touches on two areas of existing social work research that bring out different aspects of the distribution of professional responsibility. It then connects these empirical studies to Freidson's (2001) theory of professions, to bring out the interconnected character of division of work, moral obligations, and expertise in professional social work in institutional settings.

The first group of research has broached the theme of distribution of responsibility in relation to the international trend of specialization of welfare services (Grell, Ahmadi, and Blom 2016). This is relevant here, as the rehabilitation teams, in many ways, are a manifestation of this trend. Specialization carries risks of a fragmentation of responsibility, leading to decreased efficiency and quality of work

(e.g., Bunger 2010; Axelsson and Bihari Axelsson 2006). Other studies find positive effects, such as more qualified services, as professionals become specialists in a limited area of work (Grell, Ahmadi, and Blom 2016). Thus, studies have found that a functional specialization of assessment and treatment practices may mean that assessment work is more skilfully carried out, as professionals gain a greater knowledge about their area of work (Cambridge and Parkes 2006; Minas 2005; Blom 2004). On the other hand, professionals also report a diminished knowledge about related areas of work, such as the execution of treatment, which can lead to poorer quality of assessments (Börjeson and Håkansson 1998; Blom 2004). This leads Blom (2004) to argue that a larger area of responsibility improves the social workers' holistic view and understanding of the client's situation. In these studies, responsibility is closely connected to the performance of specific tasks, and professional knowledge is, to a large extent, concerned with the technical aspect of performing those tasks.

The second group of studies emphasizes the moral responsibilities of social work professionals. When talking about responsibility in social work, it is predominantly this moral or value-based responsibility that is in focus. Most of these studies concern the content of such moral responsibility (e.g., Payne 1999; Kleppe, Heggen, and Engebretsen 2015) or how professionals cope with competing organizational and moral responsibilities (e.g., Astvik, Melin, and Allvin 2013; McAuliffe and Sudbery 2005; Kjørstad 2005), with only a few addressing the distribution of responsibility (Solbrekke and Karseth 2006; Kleppe and Engebretsen 2010). Overall, these studies tend (implicitly) to place moral responsibility with the individual professional, overlooking the fact that social workers are not autonomous agents, able to act independently of the organizational context in which they are located (Payne 1999; Lonne, McDonald, and Fox 2004; Preston-Shoot 2011). These studies do,

however, emphasize the moral responsibilities inherent in professional work with vulnerable individuals, and they see professional knowledge as an important leverage in mediating organizational pressures.

All together, the empirical studies bring forward how professional responsibility concerns both *what* is to be done and *how* it should be done (Kleppe and Engebretsen 2010, 426). In his theory on professionalism, Freidson (2001, 217) asserts that distribution of responsibility for a certain area of work to a certain group of professionals is predicated on ‘the use of disciplined knowledge and skill for the public good’. Professionals – social workers and others – can ignore neither their task-based nor their moral responsibilities, even if the distribution of such responsibilities can challenge the fulfilment of both. While empirical studies of the distribution of task-based and moral responsibility within the specific setting of welfare-to-work are scarce, the existing literature does bring out the interconnection of tasks, moral obligations, and knowledge in professional practice. At the theoretical level, however, this literature contains little conceptualization of the notion of responsibility.

A conceptual framing of professional responsibility in public institutions

The concepts of responsibility have been widely discussed over the last century from social, political, and philosophical perspectives and using concepts of responsibility, duty, ethics, and so forth (Banks 2006; Sugrue and Solbrekke 2011). For the purposes of this article, ‘responsibility’ is used pragmatically to encompass the various obligations that professionals are held accountable for. Professional responsibility in institutional settings, thus, comprises features of task-based responsibility (what professionals are expected to do), technical responsibility (how they are expected to do it), and moral responsibility (what the ‘right’ thing to do is). Being responsible means being so in relation to someone or something else; in this case, to professional standards as well as

institutional ones. Which features are made relevant in relation to what standards is an empirical question to be examined below, but a few conceptual delineations are needed.

The concepts of task-based and moral responsibility build on the work mentioned in the previous section. Moral responsibility can encompass both the ethical and moral obligations of professionals (Freidson 2001) and the technical-rational ethics of modern bureaucracies, obligating professionals to work in accordance to rules in order to ensure ‘the greatest good to the greatest number of people’ (Adams and Balfour 2004).

The notion of technical responsibility is based on Bauman (1989). According to Bauman, technical responsibility concerns the standards of how a given task is performed. The institutional aspect of technical responsibility could be a ‘procedural rationality’, in which decision making is rational and appropriate when it is the outcome of an appropriate process of deliberation (Simon 1976). Technical responsibility concerns the ‘knowhow’ of work (Bauman 1989), which, in a professional setting, may include that decisions are made according to the best available knowledge (Freidson 2001). When technical responsibility gets decoupled from moral responsibility, Bauman (1989, 101) argues, focus is limited to the performance as a goal in itself, rather than as a means to achieve some other goal.

In terms of distribution of responsibility, Bauman’s (1989) work is useful, as he places both technical and moral responsibility within the context of bureaucratic organizations¹. Bauman utilizes the notions of technical and moral responsibility, and

¹ It is necessary here to underline the distinct differences between Bauman’s (1989) case and that of the rehabilitation teams. The rehabilitation teams do have the overall well-being of clients as an aim, even if that well-being is closely connected to labour-market participation. This can in no way be compared to the aims and effects of the Holocaust. Thus, I am not

describes how the division of work into smaller tasks (reflecting a task-based responsibility) limits the scope of professionals to that specific task. This, in turn, works to emphasize a technical responsibility for performing that task in professional (or bureaucratic) ways, while the moral responsibility for the overall effects of work gets de-emphasized.

Bauman (1989) calls attention to the links between the organization of work and the professional performance of responsibility, yet the actual distribution and content of performed responsibility is an empirical question. It is important to keep in mind that, in practice, team members are responsible to *all* of those features. Professionals thus have to manage their given responsibilities in practice, and it is this doing of the collected features of responsibility that is in focus in this article.

Data and methodology

The present study is based on a study examining decision making in the rehabilitation teams introduced above. As part of the project, 19 interviews with 17 team members of rehabilitation teams in three Danish municipalities were conducted. As the teams are inter-professional, interviewees represent a range of professions, as well as the four organizations obligated to be present in the teams. The distribution of interviewees on municipality and profession is presented in Table 1.

[insert table 1 here]

comparing the case of the rehabilitation teams to the case of Holocaust, but utilizing the theory of organizational mechanisms to distributing responsibility, which Bauman (1989) demonstrated with his extreme case.

The study also included observations of team meetings, and interviews were conducted after the observation of several 'typical' meetings in each municipality. Interviewees were recruited on the basis of their presence in the observed meetings. Three representatives from employment services in municipality C resisted being interviewed with reference to a lack of time, but otherwise all invited team members agreed to participate. The study was conducted in accordance to national and institutional guidelines for ethical practice and secure data management.

The interviews were conducted as individual interviews by several different researchers who were part of the research group, including the author of this article. Interviews were structured around a thematically organized interview guide focused on professional collaboration and client inclusion, and they lasted between 30 and 45 minutes. The focal theme of distributed responsibility formed as part of empirical work after the interviews were conducted, as described below.

Analytical strategy

Analysis has been done by the author alone, following the general approach of theme-oriented discourse analysis (Roberts and Sarangi 2005). This means that the interview data is approached as discourse through which professionals express their orientation to and experiences of different responsibilities.

The focal theme of distributed responsibility was identified through repeated re-readings of interview data, as well as meeting recordings and field notes. This theme has been analysed by coding the data for both explicit and implicit expressions of responsibility, in the broad sense outlined above. A second cycle of coding then ordered these expressions into three inductively identified categories of 'expressions of tasks', 'expressions of professional and moral challenges', and 'explanations and accounts of practice'. As will be illustrated below, each of these categories signals different aspects

of the distribution of responsibility in the rehabilitation teams. The discursive analysis has focused on team members' accounts and explanations, as this is where the management of tensions between various features of responsibility is brought out.

Analytically, this study used Scott and Lyman's (1968) concepts of accounts and explanations to bring out expressions of responsibility. It focuses on the basic concepts of Scott and Lyman (1968), though accounts have since been nuanced (e.g., Pomerantz 1978; Mäkitalo 2003). According to Scott and Lyman (1968, 46), accounts are statements that are used to bridge gaps between expectation and action and to explain unexpected or untoward behaviour. Therefore, team members' accounts can be understood as clues to experiences of ambivalence or responsibility strain, as accounts signal a gap between what is wanted and what is done. Scott and Lyman (1968) identify two types of accounts: excuses and justifications. Excuses are statements that mitigate or relieve the actor of responsibility, while justifications are used when actors accept responsibility but deny that the given act is wrong or unwanted (47). Explanations are different to accounts in that they are used when 'untoward behaviour' is not an issue (47). Whether explanations signal team members' perceptions of responsibility is thus dependent on the content of the statement, but when they do, explanations do not frame the given behaviour as unwanted.

When using this analytical approach, responsibility becomes not just a matter of content but also allows for insights into the distribution of responsibility at the micro-level of discourse ('what am/are I, we, and they responsible for?'). The analysis of interview data cannot, however, make any claims as to how professionals actually act out these expressed responsibilities in practice.

Findings

Responsibility for institutional tasks is delegated within the team

All interviewed persons were asked how they see the purpose of the rehabilitation teams. With minor variations in terms of emphasis, team members all defined their task as making inter-professional recommendations of interventions that can bring clients closer to work. Despite labour-market participation being expressed as the overall responsibility, statements also illustrate some nuance to this goal, as the task is to bring clients 'as close to the labour market as possible'. The formal definition of the rehabilitation team states that the teams are to make recommendations on benefits as well as interventions, yet the aspect of which benefit to recommend for the client is not prominent in statements relating to the shared task of the team. However, this aspect of the team's work comes out in relation to the individual roles of team members.

When asked about their individual roles as professionals in the team meetings, the responses reflect a clear delineation of responsibility between the team members representing the employment services and the ones representing other organizational affiliations. This is illustrated in the following quote:

Excerpt 1:

Well I will say personally, I'm not very strong in the legislation and since that is the playing field we're in, I'm thinking the ones who are here from the Jobcentre, in terms of the legislation, they can trump me at any time. Because I can't discuss that with them, because I simply don't know the legislation like they do. So yeah somehow I'm thinking I'm a consultant in this context, who can offer my input in terms of what can be put into a resource programme or in terms of what view of the client that is here, and then it's their assessment,

you know, of whether a client meets the criteria for flexible employment. I don't have a lot of knowledge on that.

Health services / physiotherapist, Municipality B

Team members describe their roles as being tied to their professional knowledge and knowledge about available interventions in their respective organizations. While they explicitly take responsibility for applying their professional expertise to the situation of the client, they distance themselves from the role of actually making the decision as to which benefit to recommend. This is evident in designations such as 'consultant' or 'advisor', signalling that they advise someone else on the decision to be made, as well as the more explicit assignment of responsibility to the representatives from the employment services.

The representatives from employment services themselves acknowledge a similar distribution of responsibility for decision making, though they place more emphasis on the shared character of the work, as illustrated in the quote below.

Excerpt 2:

Interviewer *And the assessments or decisions that is made at the meeting. Do you have a special role in that or how do you perceive that?*

Professional *It's very shared. You know everything that is done, what we kind of suggest in terms of interventions, that comes from different places, and we, well OUR dialogue it seems very shared in the way that we think together, where do we think this is going. Of course I may be the one that takes like a final decision. Sometimes I feel they lean on me a lot because it's the employment system that's the most – you know, it's flexible employment, resource programme or recommendation for disability pension, so you can say, the others probably*

lean a bit on that, that it's under our remit those decisions are to be made, right. So I can be the one that – if there's disagreement, but otherwise I feel that mostly we agree on where the case is going.

Employment services / social administrator, Municipality B

The employment services representative here stresses that the common practice is that of a shared decision. At the interactional level, this is evident in the repeated and emphasized use of the pronouns 'we' and 'ours', as well as such words as 'shared', 'together', and 'agree'. His/her own decisive role is presented as the exception, occurring in relation to rare instances of disagreements, while the other team members may 'sometimes' lean on him/her.

These statements express the task-based responsibilities of the rehabilitation team members. The quotes reflect a tendency for team members to stress their role in recommending interventions while distancing themselves from the recommendation of benefits. Team members from outside the employment services delegate responsibility for recommending benefits, as well as the final word on decisions, to the representatives from employment services, while the latter stress the shared nature of recommendations. In practice, the recommendation of benefit is frequently a denial of the benefit that the client would like (disability pension), while the recommendation of interventions is an offer (feasible or not) of resources that the client may benefit from. On the one hand, then, this team internal distribution of responsibility can be seen as a way of distancing oneself, personally, from the more challenging part of the work – a matter of coping. On the other hand, the literature on specialization has illustrated that a specialized organization will lead to specialized bodies of knowledge (Grell, Ahmadi, and Blom 2016). In many ways, this is what is reflected in the interviews, as team members orient

to their own and others' roles in terms of their professional backgrounds. Excerpt 1 illustrates how the delineation of responsibility between consulting on interventions and deciding on benefits is expressed as being a consequence of the knowledge of the respective team members. Team members thus express both their task-oriented and moral responsibilities as a matter of contributing their professional knowledge. However, interviews also contain expressions of the professional and moral challenges of being part of the rehabilitation team.

Moral challenges are a responsibility of the individual professionals

In interviews, team members express overall satisfaction with being part of the rehabilitation teams, but talking about their tasks also brings out various aspects of the work that challenge the fulfilment of these tasks. The main challenges reflect a concern that clients do not get the help they need due to a lack of organizational resources, as well as contradictions between the clients' wishes and abilities and the policy demands of labour-market participation. Statements concerning these challenges are expressed in terms of individual issues of ambivalence and discomfort. The following two quotes illustrate two different aspects of this.

Excerpt 3

Because it's about getting them onto the labour-market. And well, my education is more about saying 'what does the client want to achieve?' And that was a big challenge for me in the beginning, to having to say all the time, that I might have a sense that the client would perhaps rather work with something else. Not in terms of an occupation, you know, but work toward another goal. But because it is a labour-market-perspective

then that has to be the goal, or education has to be the goal, and I'm used to, from my education, to say 'well, what does the client want'. Tell me a goal and then we work toward that.

Health services / physiotherapist, Municipality B

Excerpt 3 illustrates the moral ambivalence some team members express in relation to finding themselves to be part of the employment services and, thus, the approach of welfare-to-work that defines work as the ultimate goal regardless of the wishes of the clients. The challenge of having to work towards labour-market participation while dealing with clients with complex health and social issues is seen in almost all interviews, although the extent of discomfort varies. While the physiotherapist in excerpt 3 expresses the ambivalence in terms of being caught between his/her professional values and the policy context of the teams, the social worker in the following excerpt describes the challenge of trying to include clients in the meetings themselves.

Excerpt 4

But that is again that thing about, even if you sit there saying 'what do think about this' and 'does this sound completely crazy compared to your ideas', then I'm not sure whether they can relate to that in that forum and look at it clearly. But it's a way of trying to include them as much as you can. [...] Sometimes, if you were to take the clients' role, if you have these clients that are not actively participating, I find that incredibly uncomfortable, because I almost get the sense that I'm violating a human being, to say 'well we're

thinking—’, and then you say ‘hm’. I had one one day, that just sat like this and there were no response at all and I just found that so uncomfortable. Then I would rather have the ones that scream and yell and get bloody angry because at least there is a reaction that you can follow up. The other situation I just find so uncomfortable.

Employment services / social worker, Municipality A

In the teams included in this study, the representatives from the employment services will most often hold the chairing role, making them the main persons to communicate with clients during meetings. Excerpt 4 illustrates the challenges of ensuring the client’s participation in a highly formalized setting and reflects an orientation towards a responsibility to do so. In both excerpts 3 and 4, these challenges are expressed as being emotionally taxing personal issues (‘I had to get used to’; ‘I get a feeling of’). This is reflective of the interviews where ambivalence around moral responsibilities is consistently expressed as personal challenges. This is in contrast to the task-based responsibilities described above, which were expressed as either a shared team task or related to professional knowledge. Perhaps because the challenge arises in relation to the overall policy goals themselves, moral issues become individual responsibilities that require professionals to evaluate their work in the rehabilitation teams in terms of their own (professional) conscience. While these expressions of ambivalence do signal an orientation to the moral responsibilities of concern to the client, as well as a conflict between task-oriented responsibilities and moral ones, the distribution of responsibility gets clearer when looking at how professionals account for their practices.

There are different ways of managing tensions between responsibilities

In interviews, professionals offer various accounts of how teams and team members manage the challenges described above. These statements take different linguistic forms that defer responsibility or justify actions in different ways.

Deferring responsibility to legislation

Accounts and explanations that reference the legislative premise for the team's recommendations are one recurring theme when team members describe how they manage tensions between what clients want (and what they as professionals perceive as relevant) and what can be recommended formally. Excerpts 5 and 6 illustrate this.

Excerpt 5

But when it comes down to it, they have to go through this resource programme, if it's a 25 year old, they don't get a pension, you don't, unless you have been through a resource programme. So in some ways I don't think it's our fault, because I don't think we've been given much to work with, because we have to deliver something that is doable within the law.

Health services / nurse, Municipality A

Excerpt 6

I feel it's rare that we completely disagree [with the representative from the employment services]. And often we will agree, perhaps, that it might be a really good with a disability pension, that that would benefit the client the most, but there is no legal authority to do so. And then that is how it is.

Social services / occupational therapist, Municipality B

Excerpt 5 has the features of an excuse, in that it is an account for a dis-preferred situation (that clients' wishes cannot be followed) and that responsibility for this

situation is deferred elsewhere; in this case, the obligation to work within legislation (Scott and Lyman 1968). Excerpt 6 contains an explanation of how team members handle disagreements. In this case, there is no presentation of a 'gap' to be accounted for, and the precedence of legislation over what is appropriate for the client is stated in unequivocal and non-evaluative ways ('that is how it is'). In both instances, responsibility is deferred to the legislation, as team members are presented as having no choice, even if they or the client disagrees.

Emphasising professional responsibility of the inter-professional team

A second subgroup of statements contains accounts of how the team's inter-professional work contributes to clients' cases, even when there is ambivalence related to the moral responsibilities towards the clients. Consider the following two excerpts:

Excerpt 7

It has been important to us to find a purpose for us to sit here, because several people have found it hard to sit here, for personal reasons too. But I get my professionalism put into play and we have seen repeatedly that we have been able to contribute with something, that the professions that have sat with this on their own, that is the caseworker occupations, there are things they haven't been aware of, there are things simply, that they haven't known. It can go both ways, that there are clients that have been given up in terms of work, because they didn't know that there were these units within the same municipality, that could do something for these clients, so they could move on. Also just in terms of quality of life. It may be that they can't work anymore, but they can get better mobility, less pains so they get less exhausted at home, that direction too.

Health services / physiotherapist, Municipality A

Excerpt 8

The only fair thing is to say, that what we can offer is a right to be heard. You can be heard and you get to say what you like, and then we get things inter-professionally which hopefully means a better quality.

Employment services / social worker, Municipality A

As the excerpts illustrate, statements of this kind acknowledge the problems related to not being able to follow the client's wishes, yet they justify these by referencing the inter-professional character of the team's work. By doing so, team members accept responsibility for their recommendations and, to some extent, acknowledge the negative aspects thereof, but they assert the positive value of the act nonetheless (Scott and Lyman 1968, 51). These statements thus assert the claim that while the work of the rehabilitation teams is not without challenges, it is better than if they were not there. In the excerpts above, we see this by the claim of contribution to the client's best interest in excerpt 7 and the reference to a 'better quality' in excerpt 8. These claims pertain to the overall work of the rehabilitation team and place emphasis on the benefits of the inter-professional knowledge of the teams.

Emphasising the professional responsibility of the individual

The third subgroup also contains justifications but does so in relation to the individual professional. The first excerpt below is taken from a sequence where a medical doctor explains how she/he will sometimes declare disagreement with the recommendation of the team in the written recommendation itself. Where the above quotes (7 and 8) justified the recommendations and the teams themselves, the quote below is a justification of the individual professional's participation in a team she/he does not always agree with. In cases where a shared agreement cannot be reached, individual

team members have the option to have a note of this written into the formal recommendation of the team.

Excerpt 9

Interviewer *Where the rehabilitation team recommend one thing and you actually don't support that decision?*

Professional *It may not be written crystal clear, but it may be in the text, worked in that, perhaps, 'the health coordinator express that prognostically there is nothing to build on', or 'in terms of treatment all options are exhausted', or 'health coordinator assess the situation to be permanently and considerably reduced'. For instance in a case for flexible employment then that can be articulated, so no one needs to go home from that meeting and think that you didn't – or that it haven't shone through, that you have had a professional approach.*

Clinic for social medicine / doctor, Region A

The statement is an account, in that it offers an explanation of an unwanted situation, the inability to reach a shared agreement. This is brought up in relation to the stated challenge of having to work towards labour-market participation with vulnerable clients, similar to the challenges described in excerpts 3 and 4 (not reflected in the quote). While accepting that this is a challenging situation, the doctor justifies her/his participation with reference to a (more or less) explicit declaration of disagreement. In this case, the positive value is asserted in relation to being able to uphold a professional stance ('that you have had a professional approach').

The following quote takes a similar format but in relation to a different challenge, that of being under pressure from one's organization not to facilitate an

increased demand for services, while being part of a team where the recommendation of services is a core part.

Excerpt 10

Because that is the role we have. Our role is to contribute with the knowledge and the experience we have from the social psychiatry, and if that means mentioning that the client in question could benefit from a §85², well then that is what we'll say. And that's not a question of whether I have granted it, or promised – I'm still quick to say – [...] I'm still quick to say, that it's not something we can decide, but we can help make an application for a §85. Then I haven't said too much, but I have still done my job as I feel I should. You know I have to contribute with the knowledge I have. And then maybe that person can't get one. And maybe there's a waitlist for a year. And maybe it's smarter to put in a mentor because there's such a long wait. But at least then I've said it.

Social services / social pedagogue, Municipality C

In this quote, the situation needing to be accounted for is that of continuing to recommend services even if there are limited resources in the organization to offer this service. The justification is done with reference to the claim that the individual has 'done my job' by offering his/her knowledge. With both justifications, the individuals accept responsibility but do so in relation to their own professional obligations, while distancing themselves from the rest of the team (excerpt 9) or from their organization (excerpt 10). Once again, we see that professional knowledge is brought in to justify the

² §85 in the Act on Social Service on social assistance, often personal home support.

action, yet in this case it is done as an interest in itself ('then I've said it'), in opposition to the organizational framework.

The earlier quotes (7 and 8) expressed professional knowledge as a way of achieving better recommendations and, thus, better results for the client. This may be seen as leaning towards a moral responsibility, in the professional sense. In quotes 9 and 10, the goal seems to be the stating of professional knowledge itself, regardless of whether it has an outcome in the case. In this case, team members express a more technical orientation, in which the performance of this isolated task is emphasized, while the outcome for the client becomes somewhat vague. Nevertheless, the act of stating a professional assessment that goes against organizational interests does contain a moral aspect, in terms of facilitating clients' applications for services for which they may be eligible.

Where the group of excuses signals a disavowal of professional responsibility, the two types of justifications are both rooted in professional standards of applying the respective knowledge bases of the given professionals, in both moral and professional-technical ways. These statements further situate the management of moral and professional challenges with the individual team member, as can be seen from the variation and content of the accounts. The professional and moral responsibilities are, to a large extent, expressed in opposition to institutional responsibilities of enacting legislation.

Discussion and conclusion

Professional responsibility in inter-professional rehabilitation teams is distributed in various ways and at various levels of the organization. Legislation has divided the visitation of clients to permanent benefits into separate parts of description,

recommendation, and decisions and has distributed responsibility for these tasks to separate groups of actors.

Following Bauman (1989), this distribution of responsibility into small subsets focused on the technical aspect of the work may be seen as a way to dismantle *a*) the exercise of moral responsibility by professionals and *b*) the achievement of a holistic assessment of clients' needs and opportunities for development. While the interview data do offer some support for such tendencies, it also shows professionals seeking ways to manage these challenges in professionally responsible ways. Nevertheless, the task-based responsibility of the rehabilitation team members becomes a matter of contributing interventions. The responsibility for the recommendation of benefits becomes somewhat diffused, as team members place it with the representatives from the employment services, and those representatives underline the shared nature of decision making. Furthermore, as moral responsibilities become individual matters to be handled at the personal level, the overall professional responsibility becomes a more technical orientation to contributing professional knowledge into the recommendation of a decision.

On the other hand, this study also found team members oriented to the larger issue of whether clients actually get the help they need, as well as the moral challenges of working towards labour-market participation with clients who do not see themselves capable of this. The interviews illustrate that team members do take a stance to consider these aspects in their work, despite the considerable policy and organizational pressures to the contrary. According to Bauman (1989), organizational pressures can conform professional responsibility into a matter of technical knowhow that allows for a moral indifference. Yet what we see in the interviews with team members is a tendency to defer the 'technical' aspect of assessing eligibility to the representatives from

employment services, as they distance themselves from the decisions on benefits. While the team members do stress their contribution of professional knowledge as their main responsibility, they do so in relation to suggesting interventions that could help the client, rather than limiting their application of knowledge to whether or not these interventions are available to the client. In doing so, these professionals create some possible counter pressure on the organization, as can be seen in the statements of increased demands for some services.

This does not always serve to change the overall trajectory for clients within the employment services, as the goal of labour-market participation is non-negotiable, and the team's recommendations have to be shaped around specific legislative categories. That moral and (other) professional responsibilities are contingent on individual professionals' positioning within the teams and their respective organizations illustrates the pervasive forces of the organizational distribution of responsibility.

These findings have implications for practice in that they stress the role of professionals in ensuring how their professional responsibilities are acted out. However, as Bauman (1989) establishes the organization of work as the cause of a diffused (moral) responsibility, Freidson (2001) calls attention to the importance of a moral responsibility on the part of institutions. Where practice ethics deal with the dilemmas and challenges that individual professionals face in their work, institutional ethics deal with the political, social, and economic circumstances that create many of these dilemmas. Freidson (2001) thus argues that moral responsibility be placed with the organizations (and policy-makers), rather than exclusively with the professionals. While this may mean a role for professionals in terms of voicing their experiences internally as well as externally, Freidson also points to professional associations and the general public in terms of holding institutions and policy-makers morally accountable.

As the tendency to redistribute responsibility in specialized units seems ongoing, further research is necessary that approaches the pressures on professional responsibility not as a phenomenon for the individual professional to cope with, but as a consequence of organizational and policy developments.

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Table 1. Distribution of collected interviews on number of interviewees/number of interviews in Municipalities A, B, and C.

	A	B	C	In total:
Employment services (social worker, social administrator)	2 / 2	1 / 2	none	3 persons / 4 interviews
Regional health (medical doctor)	1 / 1	1 / 2	1 / 1	3 persons / 4 interviews
Municipal health (physiotherapist, occupational therapist, nurse)	3 / 3	1 / 1	1 / 1	5 persons / 5 interviews
Social services (social pedagogue, social worker)	2 / 2	2 / 2	1 / 1	5 persons / 5 interviews
Educational counselling (teacher)	1 / 1	none	none	1 person / 1 interview
In total:	9 persons / 9 interviews	5 persons / 7 interviews	3 persons / 3 interviews	17 persons / 19 interviews