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Abstract

Collaboration has been alleged to increase quality and reduce costs in health care, however previous research shows that well-functioning integration might be difficult. This paper looks upon multi-professional teamwork from the professionals' perspective. The purpose is to study how organising processes are upheld or reshaped in a collaborative human services setting, and to explain the underlying mechanisms behind emerging organising processes. Two cases of multi-professional teamwork were studied and data collected through interviews with team members and their managers. The results suggest that it is possible to distinguish between organising processes of boundary modification and boundary preservation, respectively, where preserved legal and economic boundaries, maintenance of organisational cultures and separate service provision processes work to uphold existing organising processes, whereas disconnection of team activities from the parent organisations and the establishment of boundary platforms instead contribute to develop new modes of human services delivery. In particular, boundary platforms create meeting places for professionals to develop new ways of acting and producing services and therefore have the potential to exceed and modify physical, social and mental boundaries. Between the forces of boundary preservation and boundary modification, a tension will be induced and continuously upheld through political processes among actors.

Att bibehålla eller förändra gränser Utmaningen för samverkan inom hälso- och sjukvård

Samverkan framställs ofta som fördelaktigt för att öka kvaliteten och minska kostnaderna vid produktion av hälso- och sjukvårdstjänster, men tidigare forskning visar att det kan vara svårt att uppnå väl fungerande integration. I denna artikel studeras multiprofessionellt teamarbete utifrån de professionellas perspektiv. Syftet är att studera hur organiseringsprocesser inom hälso- och sjukvården upprätthålls respektive omskapas i en samverkanskontext och att förklara de underliggande mekanismerna bakom dessa organiseringsprocesser. Två fall av multiprofessionellt teamarbete studeras och data har insamlats genom intervjuer med teammedlemmarna och deras chefer. Resultaten tyder på att det går att skilja mellan gränsbevarande respektive gränsöverskridande organiseringsprocesser. Juridiska och ekonomiska gränser mellan vårdgivare, etablerade organisationskulturer och åtskilda serviceproduktionsprocesser bidrar till att bevara existerande organiseringsprocesser i samverkanskontexten. Å andra sidan utgör särkoppling mellan teamets aktiviteter och moderorganisationerna samt etablering av gränsplattformar de viktigaste mekanismerna som bidrar till att utveckla nya hälso- och sjukvårdstjänster. I synnerhet skapar gränsplattformar mötesplatser för professionella att utveckla nya sätt att agera och producera tjänster och dessa har därför en potential att överskrida och förändra både fysiska, sociala och mentala gränser. Mellan krafterna gentemot gränsbevarande respektive gränsöverskridande uppstår en spänning som kontinuerligt upprätthålls genom aktörernas politiska processer.

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Introduction

Among numerous reforms to remodel the health care and social services sectors in order to, allegedly, increase flexibility, competence, service quality and cost effectiveness¹, collaboration between service providers has received increasing attention throughout most of the Western world (see for example 6, 2004; Agranoff & McGuire, 2003; Entwistle & Martin, 2005; Hill & Lynn, 2003; Rodríguez et al., 2007). Generally, human services are highly specialised in terms of agencies, professional competencies and geographical responsibilities. Current trends towards medical sub-specialisation and NPM-ideals of competition (Hood, 1995) also contribute to this situation. While obviously being a major force towards value creation, possible drawbacks from specialisation include poor communication between providers, double work and fragmented care taking of clients with complex needs (Bardach, 1998; Farmakopoulou, 2002) while collaboration has been argued to contribute to reduced costs and/or increased service quality (Bronstein, 2003; Danermark & Kullberg, 1999; Entwistle & Martin, 2005). Overall, the collaboration trend could be considered a reflection of general ambitions, evident in both academic as well as in practice discourse, to discard of directive and controlling forms of policy development and instead traversing sectorial as well as organisational boundaries (Rodríguez, et al., 2007). Accordingly, organisation research has paid “enormous” interest to inter-organisational collaboration, as argued by Rodríguez et al. (2007:150).

Notwithstanding the alleged benefits of collaboration, previous research is ample with examples of this being a laborious pursuit. For one thing, legal boundaries could prevent the exchange of information and financial resources between service providers (Lindqvist & Nylén, 2002). Furthermore, collaboration requires that the involved agencies partly give up their autonomy for a common endeavour and so political protectionism might hinder integration (Bardach, 1998; Seeman, 2001). Additionally, differences in professional perspectives as well as status differentials could seriously hamper professional actors’ readiness to collaborate (Hugman, 1991; Hvinden, 1994).

In addition to these challenges, the concept of collaboration has come to represent a lot of different empirical practices, ranging from informal communication initiated by professionals to formalized agreements between agencies on care pathways or joint financing of establishments (Alter & Hage, 1993; Hill & Lynn, 2003; Nylén, 2007). One particularly interesting type of collaboration is represented by the multi-professional teamwork that is meant to combine resources and competencies of several agencies and professions in order to serve complex and interrelated client needs (Adler et al., 2005; Bihari Axelsson & Axelsson, 2009; Thacher, 2004). Team members from different organisations and professions are here expected to interact quite closely in order to develop joint services. Actually, this trend towards teamwork in human services conveys ideas from the business world on delayering and self-governance for increased effectiveness (Payne, 2000:35). Teamwork, it is argued, contributes to renewal, flexibility and advanced problem solving in traditional manufacturing work as

well as knowledge intensive services (Lind, 2009:191), hence asserted to replace bureaucratic regulations (Carlström, 2009:244). So the multi-professional team represents one possible means to arrange for collaboration in human services; however the research issue raised is whether new modes of service provision really emerge, or if established ways of working and interaction with colleagues and clients are too deeply rooted? Teams may actually become “pseudo-teams” when the interdisciplinary collaboration isn’t working (Beck-Friis 2009:33).

For collaboration to really make a difference for content and quality in health care, the involved professionals must change their perceptions, both of themselves and the work they are supposed to carry out, as well as of other actors and their role in the human services system. However, when procedures for managing and producing services have long-term roots in the experiences, traditions and expertise of involved actors, these procedures tend to become repetitious and stiffen into structures and *boundaries* between actors (Hernes, 2003; Hosking & Morley, 1991; Weick, 1979). So if health care organisations are to develop new practices for service delivery, then *boundary modification* appears as a key issue. Still, previous research suggests that existing boundaries could be quite resistant to attempts to dissolve or traverse them; instead, they may even be strengthened, if collaboration is perceived as a threat to one’s self-perception and valued professional identity (Currie et al., 2008; Rodríguez et al., 2003; Turner, Pratkanis & Samuels, 2003). It could even be argued that the organisation is “essentially a boundary maintaining system”, as put by Hernes (2003:35). One explanation for this is that actions and activities in organisations are shaped by the perceptions, values and identities of involved actors – such as health care professionals – which may not be so easily transformed. Moreover, power relationships among actors and actor groups will affect whether the “pro-collaboration” actors are able to influence and change established practices and solidified ways of interacting.

The purpose of this paper is therefore to study how organising processes in the human service sector are upheld or reshaped, respectively, in a collaborative setting, and to explain the underlying mechanisms behind the organising processes that emerge in the collaborative context. In particular, two cases of multi-professional teamwork will be analysed in order to identify how boundaries are preserved or transformed as health care professionals attempt to implement collaborative practices.

Theoretical framework

Collaboration has previously been studied from various theoretical perspectives (see e.g. Rodríguez et al, 2007:151), but in order to understand collaboration from the point of view of the directly involved actors, a social-psychology view will be applied in this study. This perspective views coordinated social action as constituted by continuously on-going processes of interaction among actors whose behaviour is based upon their perceptions and interpretations of the world, which in turn are framed by existing social and political structures of

power and influence (Hosking & Morley, 1991). Their actions and interactions form into verbal and non-verbal acts that over time may stiffen into routines, structures and boundaries (Hernes & Weik, 2007). An organisation, such as a health care agency, could theoretically be seen as “a temporarily structured state constantly involved in processes of construction and reconstruction” (Hernes & Weik, 2007:260). More concretely, organising processes could in this context manifest in service provision processes, managerial procedures and – possibly – collaborative activities.

Furthermore, interactions among actors will evoke processes of social categorization, meaning that people come to view themselves and others in terms of which category/ies one belongs to, such as gender, ethnicity, occupation, workgroup, organisation etc. *Similarities* among actors within a particular category as well as *differences* to others are hence accentuated, creating social, mental, and physical boundaries between actors and actor groups (Hernes, 2003; Hosking & Morley, 1991; Weick, 1979). Also in the human services context, numerous types of boundaries are evoked; not only legal and economic boundaries between agencies but also structural and administrative boundaries between work groups, organisations, and levels of care. Further, professional boundaries between areas of competence and responsibility are often claimed to be particularly influential for understanding human interaction and organising processes in this context (Atwal & Caldwell, 2002; Denis et al., 1999; Currie et al., 2008; Hugman, 1991). Prevalent boundaries are essentially socially constructed, but may absorb people’s cognitions, i.e. become mental, or manifest in physical and geographical distances. Social, mental and physical boundaries may to different extent overlap or diverge and contribute to structure and stability in organising processes.

An actor’s self-definition in terms of belongingness to important categories, i.e. one’s social identity, will thus influence the person’s behaviour, values and norms (Hogg & Terry, 2001). Relating to a positive social identity is valuable for the individual in order to gain predictability, self-esteem and status in a complex world (Tyler, 2001). Evidently, people are embedded in a multitude of relationships and hence belong to several social categories, both privately and at work, but focus will here be placed on categories and accompanying boundaries mostly relevant for human services production. Here, actors are often categorized as politicians, administrators, professional service workers, or clients/patients; each with their own set of values and interests (cf. Kouzes & Mico, 1979). In order to understand organising processes in a multi-professional teamwork context, focus should primarily be placed upon the identification of professional actors since they exercise considerable influence over service production processes (Lipsky, 1980; Denis et al., 1999).

The professional category may be further divided into institutionalised fields of medicine, nursing, education, social services, etc., each of which has its own work methods, normative grounds and view on the client (Ackroyd, 1996; Grape, 2006; Lindqvist & Nylén, 2002; Wingfors, 2004). Previous research suggests that social identities ascribed to different professions might be highly

valued by the individual, providing him or her with status and self-esteem, but also leading to cognitive barriers that impede upon actors' ability to communicate and collaborate with each other (cf. Atwal & Caldwell, 2002; Currie et al., 2008).

It should therefore be expected that members of a multi-professional team would rely on partly diverging behavioural norms and cognitive views. Collaboration arrangements that force professionals to co-operate closely with other professional groups might actually be at odds with the professional group's strive for self-definition and self-enhancement, and so existing identities and organising processes may be quite persistent towards boundary modification attempts (Currie et al., 2008; Hugman, 1991). Being placed in a multi-professional team could even *increase* the salience of the professional identity, as differences in view on work and clients as well as professional skills and experiences become further accentuated (Haslam, 2001:42ff).

Further, there are typically status differentials among professional groups, for instance with the effect that physicians is regarded to hold a privileged position in relation to other groups in the human services sector (Currie et al., 2008; Taylor & White, 2000). Similarly, Hugman (1991) argues that social workers are less prestigious in the public's eye than for example nurses, and that this external status difference also affects their bilateral interaction. Power relationships among actors are created and upheld through organising processes involving negotiation, persuasion, or coercion (Brown, 2002; Hosking & Morley, 1991) during which structures of dependency are evoked. When each actor group could independently contribute their piece to the overall provision of human services, their mutual dependency is low, or "pooled", according to Thompson (1967). On the other hand, service provision processes may also connect sequentially (Thompson, 1967), hence creating a need to interact over established boundaries. However, since one actor group is then one-sidedly dependent upon another, this asymmetry in actors' interdependencies could create tensions and anxiety (Bloisi et al., 2003). For truly joint service production processes to take place, activities and procedures based on reciprocal dependencies (Thompson, 1967) must emerge among equal partners, thereby modifying existing boundaries.

Accordingly, the way human services tasks are connected will reflect upon any attempts to interact across boundaries. Actually, Lindberg (2002:56) argues that loose coupling between activities within an organisation facilitates for external connections. Previous research has also highlighted the importance of certain individuals taking upon themselves to integrate different social settings, i.e. so-called "boundary spanners" (Tushman & Scanlan, 1981). These individuals have a good connection to both settings and are able to establish formal and/or informal links. Similarly, Star & Griesemer (1989) point towards the role of "boundary objects", which connects actors from different social worlds. A boundary objects could for instance be a concept or a standardized work method (Star & Griesemer, 1989:410) or, as in health care, the client him/herself as being the focal point in a chain of care shared by several providers (Lindberg, 2002). The object could actually take on different meanings within the respective

worlds but still allow for communication and collaboration among actors. However, research on boundary spanners and boundary objects has mainly concerned large social systems and it is not evident that the same mechanisms will apply also in a relatively small multi-professional team.

Nevertheless, through continuous interactions in the team context, team members may over time develop a sense of identification with their new group, either by expanding their existing identity to include also the other category or by developing a dual affiliation to both the original and their new social setting (Haslam, 2001; Guerra et al., 2010; van Knippenberg & van Leeuwen, 2001). Actually, such recategorization should be a requisite in order for collaboration to really affect established modes of human services provision; however recategorization is usually a gradual process that might take considerable time (Binder et al., 2009:852), implying that the extent to which boundaries are preserved or transformed through multi-professional teamwork should in part be dependent upon time duration.

To conclude, the theoretical framework outlined above suggests that professional actors who are brought together in a multi-professional teamwork will bring with them values and perceptions from their previous contexts. From their personal identities as professionals incl. their relative power positions they will contribute to organising processes. In order for new modes of service provision to develop in the teamwork context, existing boundaries between actors and actor groups must be reshaped and new organising processes must emerge; however it should at least to some extent be of matter of time for individuals to change their social identification and, with that, their way of acting and interacting with others.

Methodology – Case study approach

The case study approach has been chosen in order to gain in-depth access to the perceptions, values and interactions of professional actors involved in multi-professional teamwork. When selecting the appropriate case, one criterion has been to find a team set up for long-term purposes, since a comprehension that interactions are temporal might affect actors' behaviour in a project-based team. In order to engage different types of boundaries, at least two human service agencies and several professional groups should be involved. It may also be advantageous if the team is in a physical sense held separate from the respective parent organisations in order to see the effect of shifted physical boundaries.

The chosen form of multi-professional teamwork is the so-called “family care centre”, which is a joint venture between local authority and county council set up with the purpose to increase quality in health and other services towards families with pre-school children. During the last decade, family care centres have been established on a larger scale in Sweden (currently, there are almost 200 centres). The design may vary due to local circumstances, but generally includes *maternity care*, a legally prescribed medical undertaking where midwives provide health checks during pregnancy; *child welfare*, i.e. health and

development checks of pre-school children by nurses; *open kindergarten*, a local authority undertaking performed by pre-school teachers and intended for children whose parents are on parental leave or otherwise not working outside the home; and *preventive social services*, where social workers offer social support and advice to target families. The basic idea behind the family care centre concept is to encourage collaboration between professions in order to prevent, or better handle, social and health-related problems among small children (Abrahamsson & Bing, 2011; Bak & Gunnarsson, 2000). In practice, this could manifest in for instance efficient referral routines or mutual guidance among team members or in development of new, joint services towards families.

To increase analytical scope of research, two separate cases were chosen: one recently established family care centre and one that has been running for several years. As mentioned previously, established professional identities and service provision processes could be expected to be quite resistant to attempts to develop new, collaborative practices. The choice of one new and one established case makes it possible to identify both similarities and differences related to time duration, which might contribute to our overall understanding of how organising processes are upheld or reshaped in a collaborative setting.

Suburb centre is the newly established family care centre, situated in a city district of a larger town. *Village centre* is the well-established family care centre, located in a small community. The main source of data collection has been non-structured interviews with all team members² and with their managers, in total twenty interviews; each lasting 1,5 – 2 hours. All interviews with team members took place in a meeting room at the respective family care centre; an undisturbed environment for the interviewer and the respondent to interact in a trustful and friendly atmosphere. Interviews with managers were conducted at their respective offices behind closed doors and telephones shut off.

Ethical considerations have been interwoven in all parts of the research process (cf. Widerberg, 2002:189); for instance all respondents and both centres have been made anonymous; each respondent has read and accepted his/her interview transcript; and each team has been given oral as well as written feedback of the researcher's findings and interpretations where individual viewpoints were not identifiable. Furthermore, considerable attention has been placed upon understanding each respondent from his/her point of view in an open and non-judgmental manner.

Below follows an overview of the actors interviewed. Please note that all actors from one parent organisation have been given the same initial letter in their pseudonyms.

Table 1. Overview of cases and interviewees

Agency Activity	CASE 1: Suburb centre			CASE 2: Village centre		
	Parent organisation	Interviewee	Pseudonym	Parent organisation	Interviewee	Pseudonym
Local authority						
Open kindergarten	Social services department (A)	2 pre- school teachers	Alice, Adrian	School department (C)	2 pre- school teachers	Camille, Carolyn
		1 manager	Alva	“	1 manager	Cybil
Social services	“	2 social workers	Anne, Amy	Social services department (D)	1 social worker	Diana
	“	Manager: see above		“	1 manager	Debby
County council						
Maternity care	Primary care centre (B)	2 midwives	Betty, Barbara	Primary care centre (E)	2 midwives	Emily, Edith
Child welfare	“	2 (of 3) district nurses	Bianca, Beatrice	“	2 district nurses	Erica, Elaine
	“	1 manager	Bridget	“	1 manager	Ernie

Case results do not intend to mirror some external, objective reality; instead, data are actively constructed in interaction between interviewee and interviewer. Hence, interviews become a way of gathering “narratives from the field”, which, in turn, could be utilized to construct a “narrative about the field” (cf. Czarniawska, 1998). All interviews were transcribed in full and compiled to a reconstructed narrative for each actor. These narratives have not been included in this paper, due to space limitations. From these individual stories, case-specific narratives were prepared, which are presented in the next section. A comparative, thematic analysis of the two cases was then conducted, which highlights the particular boundaries that are evoked, upheld or possibly modified in the cases under study. These findings are then further discussed in light of the theoretical framework in order to identify mechanisms behind boundary modification or preservation.

Empirical study: narratives from the field

Case 1: Suburb centre

The first plans for starting up a family care centre at this district were made already ten years ago when the social services district office and the primary care centre were located in the same building. At that time, some attempts were made

to develop collaboration; one initiative was that a child welfare nurse should visit open kindergarten once a week to advise families with small children. It was, however, considered that a more stable mode of collaboration was needed and plans for a family care centre were drawn up. A group of representatives from social services, open kindergarten and primary care was formed and went on study trips to previously established family care centres in Sweden. Eventually, a draft design for a family care centre was ready to be decided upon by the respective agency's top political boards when, suddenly, local primary care actors, headed by the child welfare physician, changed feet and opposed to the draft design. In particular, the idea that four social workers should work at the centre with full "exercise of authority" was questioned. The current manager of primary care, Bridget, was herself not around at that time, but explains that county council actors were thinking that parents might fear that social workers could "*take their children away*". Similarly, Beatrice, district nurse, emphasises the trust that nurses enjoy from the public:

I have never experienced not being let in on a house call – all parents let you in. [- - -] I have never been asked to show identification. [Interviewer: That is not the case for social workers?] What do you think? People have prejudice against social workers.

So there was a complete breakdown of the planning process. Local authority actors exhibit a lot of frustration regarding this event. Anne, social worker, describes how she completely "*ran out of steam*". A couple of years later, however, top policy makers in the county council and the local authority made a decision in principle to start up a number of family care centres in the region – including one at this district. Local actors were thus forced to resume the planning process and find a compromise on centre design. The solution eventually reached at implies that two instead of four social workers should work at the centre and that they should only be able to make decisions on social support after application from parents, but not handle reports on abuse or make compulsory decisions against the pronounced wishes of parents. All actors, incl. social workers, now show agreement to this solution. It did require some re-organising of work at the social services city office, which has affected the work situation of the remaining social workers:

We no longer work with the most difficult cases, the crisis cases. And so they [the other social workers] have suffered. (Anne, social worker)

At the time of interviews, the centre had been running for about half a year, having two-headed management: Alva and Bridget (see table 1). The suburb centre is situated just opposite the primary care centre but far away from the social services city office.

From the outset, team members were determined that there should be a coordinating function for the team. In order to encourage collaboration and not run the risk of favouring one agency above the other, it was decided to split the coordinating function between the two agencies. Alice, a pre-school teacher who

had participated during planning and start-up, and Betty, a midwife who came in after restart, agreed to share the responsibility for coordination of team activities. The role of the coordinators is to handle practical matters incl. joint purchases, prepare information material, answer to external inquiries – and, generally “*add fuel to the engine in the train of collaboration*” as put by Adrian, pre-school teacher. Several interviewees stress the importance of having one coordinator from each agency. Bridget, primary care manager, explains that the county council and the local authority are like “*different worlds*” where work routines, language and culture differ.

Coordinators also take turns in taking notes at the “house meetings” when the team meets for one hour each week to discuss joint issues. There have been a lot of practical issues for the newly established team to deal with; for example opening hours or equipment of localities. However, the team also attempted to discuss development of joint services such as parental education, which will be further described later on. Some members, especially from the county council side, found it hard to set aside time for joint meetings, being fully booked with patient visits, which evidently gives rise to complaints from other team members. Barbara, midwife, tells me that she prioritizes the pregnant women before meetings. District nurse Bianca feels that certain team members don’t understand nurses’ tight work situation:

I have to vaccinate all three-month olds; they must see the doctor at five and a half months and so forth...

Anne, social worker, describes the work conditions among county council actors as being highly structured and explains that she could probably more easily control her work situation and set aside time for meetings and spontaneous communication with team members. Furthermore, local authority actors argue that the culture of the county council culture is hierarchical and people are not used to collaborate.

The two managers participate in every second house meeting in order to stay involved in centre activities and, possibly, make decisions on matters that involve resource allocation or else require formalized decisions. Team members seem to be in agreement that managers are interested in and supportive of the suburb centre activities. For instance, each manager has allocated 25% of a full-time for the coordinating function. “*We really feel backed*”, says social worker Anne. A formalized collaboration agreement between the agencies prescribe the basic terms of the joint venture, for instance how costs for localities should be divided. Otherwise, team members consider themselves to be quite self-governing; performing their daily work without much need of managerial support or directives and handling scheduling of coffee breaks, new services development and other joint concerns within the team.

Individual team members also meet regularly with their respective manager, however to quite varying extent. Bridget runs into her centre employees quite often as nurses and midwives have to check in and out at the primary care centre every day. Still, Barbara, midwife, comments that collaborating with primary

care actors has become more complicated, for instance spontaneously getting in touch with a doctor for consultation. Since district nurses work part-time at the primary care centre with other nursing tasks, they actually spend considerable time there. Bridget makes a schedule for the nurses every week and district nurse Bianca explains that if there is a shortage of nurses at the primary care centre, the manager may reallocate child welfare work time to the primary care centre.

The two social workers both work half-time at the suburb centre and half-time at the social services city office and claim to really appreciate having dual working sites. Anne explains that her professional identity is based upon her colleagues at the city office. Similarly, Amy believes that the suburb centre still has not got the kind of friendly atmosphere that she is used to, for instance spontaneous chat in the corridor. Here, many team members spend their days with their respective visitors behind closed doors, and not everybody shows up for coffee or lunch breaks either. Pre-school teachers on the other hand, spend all work time at the centre and so Adrian claims to have rarely ever been to the social services city office, which he formally belongs to.

In Sweden, child welfare and maternity care are obliged to offer “parental education” to expecting and newly become parents, respectively. Nurses and midwives thus need to gather parents in small groups (5-8 couples) to discuss issues related to pregnancy, delivery and infant care. The parental education takes place during a number of group sessions running from the last part of pregnancy to the first months after delivery. In the suburb centre, team members agreed that parental education would be a concrete way to collaborate and increase the service quality by bringing in more professional competencies. The matter was thoroughly discussed on several house meetings but no action was taken until several months later when the midwife coordinator started a “pilot group” of expecting parents where also other professions would participate, and persuaded the other midwife to do the same. There was no joint planning beforehand, but social workers and pre-school teachers were invited to join in some of the sessions. Social worker Anne tells that when she participated, she informed about legal and economic issues concerning parenthood, but she was not really satisfied with this limited contribution. Pre-school teacher Adrian has participated in other sessions where he takes the fathers aside for discussions on views and expectations on parenthood (while the midwife takes care of the mothers); Adrian considers that he, being the only man at the centre, has a particular responsibility to push for gender equality among expecting couples.

After birth, the parental groups will be taken over by a district nurse and the team’s intentions are that she will also invite other professionals to her sessions. Even though this joint activity was quite embryonic, most actors express high expectations upon it.

The parental education is actually the only forum where we can really work together, where we are a family care centre. (Bianca, district nurse)

Actually, team members spend most of their working days on their respective activities that are mainly performed in the same manner as before. Some other joint activities besides parental education do take place, such as a strategic plan for the centre. Further, the team has performed a visitor survey in order to measure parents' satisfaction of the centre. There are also some signs of less structured activities incl. informal referral and advice among professionals. Barbara, midwife, explains that it has become much easier to contact a social worker when she meets a pregnant women that seems to be in need of social support. Similarly, pre-school teachers have sometimes asked district nurses on advice in case of concerns regarding the physical or social development of a child that visits open kindergarten. Actors emphasise that there are regulations on secrecy to follow, so no personal information could be transmitted without parent approval.

According to team members at the suburb centre, the co-location of activities is in itself an advantage in that parents get easy access to different services at the same place. Furthermore, actors stress that team members have begun to know each other and also learn about each other's work. Personal acquaintance creates security, says district nurse Bianca; now she understands that social workers could actually contribute with something positive to families. We have started to realise that we have a similar view on families, says pre-school teacher Alice, which increases the propensity to set time aside for joint activities. And when you start to collaborate, you actually realise that you could get help from each other, she says. So building mutual trust has been essential in this case for actors to be willing to collaborate. Alice also points out that in order for open kindergarten to fulfil its mission to provide advice and support to families, they *need* to collaborate with others. Similarly, social workers are hoping to be able to reach families at an early stage before possible social problems have escalated. Moreover, Anne wants to be seen as a "general resource" at the centre in case parents or other team members want to ask or discuss something. Still, her collaboration with other professionals has not yet been as extensive as she had expected beforehand.

Case 2: Village centre

This family care centre is located in a small community with a tradition of good collaboration between county council and local authority. Cybil, open kindergarten manager, describes that there had been on-going discussions on how to improve the joint care taking of vulnerable children. A group was formed with representatives from social services, school, and health care, which led to the development of a joint proposal for a three-year family care centre project. According to Cybil, the proposal was immediately approved by the respective agencies in a very smooth process.

When the village centre opened up (nine years before the interview study), it was actually one of the first family care centres in the region. Therefore, it has received quite a lot of public attention and the team has also received several study visits, also international ones. Several actors testify that the activities of

the family care centre have been very much appreciated by visitors and that there is a firm managerial and political support in both agencies for this undertaking.

The process towards becoming “*a spear head in the community*”, as put by Debby, social services manager, was to a large extent initiated by social worker Diana. Diana was project leader during centre development and it was very much her visions of a family care centre that determined its design, says Debby. Diana describes that it was important for her to work with families through dialogue and trust rather than formal investigations as in traditional social work. Therefore, she doesn’t exercise any authority at all, and she doesn’t keep any official records. After the three-year project period, the centre was turned into a permanent undertaking and then Diana became an unofficial centre coordinator. She describes that it has taken quite a few years for her to find a role in the team. On the other hand, her team colleagues express considerable appreciation for Diana’s work as coordinator.

She has had a very important role, already from the start. Fixing up with paper work and applications and money. That has been invaluable. But also in terms of... Evidently, collaboration under so many years fluctuates over time due to change of team members, private things etc. But then she has been a spider in the net – still, it is very good that she is not our boss! (Carolyn, pre-school manager)

Apparently, Diana has been able to keep the team together, which has contributed to develop commitment and unity among team members. The team has agreed to meet for two-hour weekly meetings and a full “planning day” each semester, where everybody participates.

The family care centre is placed in an ordinary block of flats in the centre of the village. Local authority team members work only at the village centre, thus mainly meeting their respective manager and parent organisation co-workers on parent organisation staff meetings. On the county council side, district nurses work part-time at the primary care centre whereas midwives work only at the family care centre, but they all participate in staff meetings at the primary care centre. As shown in table 1, the village centre has three-headed management: Cybil, Debby and Ernie. The managers meet with coordinator Diana a couple of times each semester, but they rarely meet with the whole team. Apparent from interviews, managers have not been actively involved in developing the village centre; instead, the team has discussed joint matters by themselves, both concerning practical matters such as internal team communication as well as joint services, and collectively decided upon them. When team initiatives require extra funding or else need to be formally approved, Diana brings it up at her meetings with the managerial group. Managers state that it has been natural for them to take this position, since the team is so competent and committed.

And I am not sure that if managers should have tried to influence more than we do today, that it would have fallen in good ground, either. (Debby, social services manager)

On the other hand, actors describe some situations where managers have one-sidedly made decisions regarding their centre employees, which have affected the workings of the whole team. Ernie, primary care manager, recently reduced the number of work-hours at the village centre for one of the district nurses, with the argument that the work situation at the primary care centre was so tight. Social worker Diana explains, with considerable dissatisfaction, that this caused problems for the team's joint activities. Her manager, Debby, describes that the team may get very upset when management takes a decision that adversely affects the village centre in favour of some other activity. She thinks that Ernie is fully entitled to consider his whole area of responsibility.

I think that because they are so self-governing and isolated, they cannot see the whole picture. (Debby)

Apparently, both the team and their managers consider the team to be a close-knit group, which contributes to advance team activities but also disconnects the team from its parent organisations.

During the work day, team members mainly deal with their respective tasks (checking pregnant women, receiving families at open kindergarten etc.); however they have over the years also initiated a number of joint activities, one being the parental education that they have worked with from the beginning and continuously attempt to improve. Team members proudly tell me about having recently introduced a new design with a pre-set outline for each session and based upon a specific dialogue technique in communicating with parents. Emily, midwife, is head of the pre-birth sessions, in total six meetings, but on several sessions she is accompanied by either the social worker or a pre-school teacher. The sessions bring up practical matters regarding pregnancy and delivery, but also demonstrate relaxation techniques and invite parents to share their expectations on the child. In the post-birth groups, the new design implies that two professionals (one of which is always a district nurse) should be present in each session. All sessions start with baby massage, which all nurses and pre-school teachers are trained at. Then the two professionals lead a discussion on a specific theme related to the interplay between the child and the parent. District nurse Elaine emphasises that it is very important not to be a "teacher" in the group but let parents share experiences and reflections among themselves.

Further, the village centre has over the years offered various thematic sessions to their visitors such as "cooking for small children" or targeted groups for young or immigrant parents. Moreover, collaboration may also take place within the professionals' ordinary work. Emily, midwives, exemplifies:

The greatest advantage in my own work is that I have Diana in the next room. I can take the woman with me and say: "You can meet with Diana here" and then they sit down and talk.

Another form of collaboration takes place during weekly team meetings where team members may share concerns over a child or family with the others and get their viewpoints and advice. This also provides an arena for broadening one's professional competence, team members say. The actors consistently em-

phasise that the community among team members and commitment to the family care centre idea is very good and trustful.

In spite of these joint endeavours, team members also talk extensively and enthusiastically about their particular jobs. Apparently, they do not intervene in each other's area of responsibility at work.

It is important not to step in and become some sort of general family care centre employee. (Carolyn, pre-school teacher)

Apart from social services, the work performed at the centre doesn't seem to differ so much compared to if it was performed within the respective parent organisation's localities. Child welfare and maternity care follows national guidelines and established programs, however district nurses emphasise that they have become much better at child welfare work now that they concentrate upon it during most of their work time. Nevertheless, the start-up of the village centre had consequences for the social service office in that most preventive work, which was previously distributed among all social workers, has now been placed upon Diana. This is valuable in order to make sure that preventive work is not pushed aside, says Diana's manager Debby, but it also makes the work of remaining social workers even more strenuous as they now "*lost the highlights in their work*". During the first years, Diana kept a relatively close contact with her parent organisation, but now she has gradually reduced her interaction with the social services' work group:

When I think about my co-workers, I think about the people working here. (Diana, social worker)

Still, it seems as if Debby would rather like more interactions between Diana and the other social workers. Also the other managers experience a gap between the parent organisation and their village centre employees. It's like pursuing a "*distance leadership*", says open kindergarten manager Cybil, and it wouldn't work unless the professionals were very competent in their roles.

Thematic cross-case analysis

The narratives from the two cases will now be compared in order to identify the extent to which existing organising processes are upheld or reshaped in the collaborative context. Organising processes comprise team members' production of existing services at the centre as well as their interaction towards development of new services. Furthermore, processes also involve interactions between parent organisation actors and the team. The cross-case analysis will be structured around themes that relate to these various processes.

The first theme in the cross-case analysis concerns *how existing services are affected by relocating to an interorganisational setting*. In both cases under study, the consequences of relocation vary between activities. The one activity mostly influenced is social work where family care centre social workers are expected to focus on preventive work, giving timely advice and support to parents. There is, however, a difference between the cases so that social workers in

the newly established suburb centre still perform some traditional social work, whereas in the established village centre the social worker only works with counselling services. Therefore, Diana's work role has changed substantially over the years whereas Anne and Amy had rather expected their work situation to change *more* than it has done, so far.

Being regulated by national standards, the medical activities of child welfare and maternity care do not significantly change when moved to a family care centre. In contrast, open kindergarten is very much dependent upon the professional's own experience and ideas and so the collaborative context provides an opportunity for pre-school teachers to improve the scope and quality of their activity.

A corresponding issue is *how the organising processes within the parent organisation are affected* by the establishment of the multi-professional team. In both cases under study, social services have rearranged their work as only centre social workers are to work with prevention. Similarly, relocating child welfare requires a specialisation as this activity is only one of a district nurse's many assignments. So *inter*professional collaboration is here paired with an *intra*professional specialisation.

A related theme is *team members' interaction with their parent organisation*. Case narratives indicate that team members actually have quite varying contacts with parent organisation actors, mainly depending upon whether s/he has single or double working sites. Spending a substantial part of one's working week among parent organisation actors seem to contribute to uphold a close relationship with the parent organisation, which is particularly noticeable in the newly opened suburb centre. On the other hand, team members who only work at the family care centre do not interact much with managers and other members of their parent organisation. In the village centre, the social worker has successively reduced her parent organisation interaction. The limited interaction contributes to viewing the team as one's major place of work and as a freestanding unit.

The next issue to be explored regards *how established processes in the parent organisation relate to, and possibly influence, the activities going on in the teamwork setting*. Firstly, it is evident from both cases that professionals work with their respective services without much interference or directives from the parent organisation. Managers express high confidence in their centre employees and usually leave it to the team to discuss and handle team matters and joint endeavours by themselves, particularly in the established centre. Being placed in separate buildings, often with quite a physical distance in between, also contributes to less parent organisation influence on team activities.

In contrast to this perceived self-sufficiency, it was obvious that the autonomy of both centres were limited: there is no common manager and no overall centre budget. The split managerial control was particularly noticeable in situations where managers one-sidedly make decisions regarding their part of centre activities. It is obvious that each parent organisation do exercise managerial control and sometimes to the effect of restricting team developments.

The overall idea with placing the four activities together is to establish integrative linkages between services and professions involved in support of families with small children. So the last, and main theme to be discussed is *what processes of interaction that arise in the teamwork setting* and, in the extension, whether new modes of service provision emerge.

Firstly, it is clear that the co-location in itself substantially increases the opportunities for interaction among professionals who previously did not know much about each other. Still, the two cases are dissimilar in that the degree of interaction and collaboration was substantially higher in the well-established team as compared to the newly established one where actors were still struggling to gain mutual confidence. Here, actors often talk about themselves in terms of “us vs. them”, seeing the local authority and county council as different worlds. In the village centre, team members felt a considerable higher attachment to their centre co-workers and joint endeavours were more developed. Both case narratives point toward the joint parental education as the most elaborated linkage between professions. Originally being a county council responsibility, this activity has been turned into a shared undertaking that all professions contribute to. The joint parental education thus constitute a new, or at least substantially modified, service towards families that has emerged in the teamwork setting. In the well-established village centre there were also other examples of joint services and other intensified collaboration in terms of client referral, professional consultation and similar.

Obviously, it takes time to settle in a multi-professional team, develop mutual trust and initiate joint activities that successively reshape organising processes. On the other hand, interaction between professionals in daily performing of their respective activities is in both cases quite limited. Seemingly, professionals from social services and open kindergarten are most eager to develop joint services; especially in the newly established centre where collaboration was less developed. Furthermore, double working sites in combination with high work load limits team interaction. Overall, this means that previously established organising processes of service production are to a large extent maintained also in the teamwork setting.

For interactions among professionals to emerge and stabilize into new activities, in both cases it seems crucial to have a pre-set time and place for team meetings, particularly since team members mainly work separately. Also planning days, joint education etc. contribute to team interactions, especially in the well-established team. Furthermore, the coordinators in the respective case have a vital role to integrate the team. In the suburb centre, the primary function of coordinators is to bridge over cultural barriers between the two agencies, while in the village centre the coordinator has been decisive for building team spirits and facilitating joint endeavours.

Summary of cross-case analysis

The main empirical findings from the thematic analysis are summarized in table 2. In the left-hand column, findings indicating that the establishment of the team has contributed to uphold previously established organising processes are presented, while findings showing how organising processes are reshaped are found on the right side.

Table 2. Cross-case analysis summary

	Empirical results suggesting that established organising processes are upheld in the collaborative context	Empirical results suggesting that established organising processes are re-shaped in the collaborative context
Similarities between cases	<p>The family care centre not constituting a formalized organisational entity</p> <p>Split managerial responsibility and control</p> <p>Managers making decisions based on overall parent organisation interests rather than specific team interests</p> <p>Professionals having double working sites, thus regularly spending work time in parent organisation localities</p> <p>The co-located service provision processes being very different in terms of work procedures, client interactions etc.</p> <p>The respective service activity mainly being performed independently of the others</p> <p>Medical activities regulated by national health programs</p>	<p>Family care centre activities being performed independently of parent organisations' activities</p> <p>Actors with single working sites having limited interaction with parent organization</p> <p>Social services activity in the team specialize on preventive work.</p> <p>Potential for increased service quality in open kindergarten activity due to co-location</p> <p>Physical proximity between team actors</p> <p>Regular team meetings</p> <p>Coordinating function in the team</p> <p>Establishment of joint activities such as parental education.</p>
Differences between cases	<p>Suburb centre:</p> <p>Social workers upholding some of previous work assignments</p> <p>Social workers maintaining parent organisation attachment</p> <p>Managers participating in team meetings</p> <p>High work load for county council actors</p> <p>Limited confidence among team members</p>	<p>Village centre:</p> <p>Social worker considerably changing work role</p> <p>Coordinator being driving force for team endeavours</p> <p>Little managerial influence in team matters</p> <p>Long-term interaction among team members</p> <p>Mutual trust and commitment</p> <p>Elaborated joint services and collaboration routines.</p>

These results will now be discussed in relation to the theoretical framework in order to further develop our understanding of the mechanisms behind these organising processes and make analytical abstractions as well as general implications.

Discussion

The case study on family care centres has demonstrated how actors relate to, experience and act upon the establishment of a multi-professional team and how the interactions in this setting contribute to team members' notion of who they are and how to act. As suggested from the thematic analysis, interactions in the collaborative context might contribute to change existing procedures, structures and boundaries, for instance in that new activities and services are offered to visitors. Moreover, positive experiences from team interactions could over time encourage the individual to "re-categorize" (Brickson & Brewer, 2001:57) to a new, team-based identity. But there is, on the other hand, a simultaneous movement in the opposite direction, of upholding, possibly even strengthening, established procedures and pre-team social identities. For instance, midwives still perform their health controls of pregnant women in accordance with national standards. Furthermore, each manager directs his/her part of centre undertakings in accordance with parent organisation goals, regulations and restrictions. It is therefore possible to distinguish between *processes of boundary modification* and *boundary preservation*, respectively. These mutually counteracting processes will now be further elaborated upon, beginning with mechanisms behind boundary preservation.

One fundamental mechanism that contributes to boundary preservation concerns the fact that certain social boundaries such as legal and economic areas of responsibility are not really altered in this type of collaboration. Thereby, professional work norms and parent organisation's structural and cultural constraints are carried into the team context. Furthermore, the many-headed managerial control over the centre may preclude team "entitativity", i.e. being experienced as a coherent unity, which should be a requirement for team identification (cf. van Knippenberg & van Leeuwen, 2001:253). Professionals' expectations upon developing new, joint health care services might thus clash with the managerial perspective where the centre is seen as one part of the organisational whole, actually accentuating the basic divergence of interests between managerial and professional actors (Kouzes and Mico, 1979). It was evident in both cases that managerial actors have by virtue of their position access to coercion as influence strategy (Hosking & Morley, 1991), which they utilize to uphold existing parent organisation procedures.

In addition to preservation of these social boundaries, the respective profession furnishes actors with varying scope of action to contribute to joint endeavours. Generally, the medical professions are both more externally regulated, which contributes to stability in service provision processes, and more prominent in the professional status hierarchy, implying that a change of professional iden-

tity may seem more threatening to one's self-esteem (Currie et al, 2008; Hugman, 1991). Secondly, most services at the family care centre allow for professionals to continue performing their work in relative isolation from each other, hence suggesting pooled interdependencies (Thompson, 1967); however social services and open kindergarten are also dependent upon well-functioning collaboration with other professions. Their disadvantaged position in the sequential interdependency processes (Thompson, 1967) is further reinforced through the professional hierarchy (Hugman, 1991; Taylor & White, 2000). When the most influential actors do not experience a need (or possibility) to collaborate, existing mental and social boundaries between professionals will to a large extent be maintained despite physical closeness.

Furthermore, professional actors' work-related norms may actually exclude more extensive team interactions. As Atwal and Catwell (2002) noted, the professional identity is very important for actors' self-esteem and so the professional identification of team members becomes closely related to the maintenance of existing service production processes. Actually, the work norms of different professions may even be reinforced in the multi-professional setting since actors come to represent their profession rather than being unique individuals and so mechanisms of "depersonalisation" (Haslam & Platow, 2001:216) also works as to preserve mental boundaries between professions. Actually, this mechanism seems quite persistent over time.

Moreover, when economic and legal boundaries correspond to professional categorization, it seems highly likely that the parent organisation will remain an important ground for the individual to interact with others within the same profession. Professional and organisational identifications become mutually overlapping, which underpins the notion of others in the multi-professional team being different from one-self, possibly becoming subjected to bias and stereotyping (Haslam, 2001:44ff). This organisation/profession overlap was noticeable especially for actors with dual working sites who maintain regular interaction with the parent organisation. On the other hand, reduced interaction between team and parent organisation actors may successively downplay actors' organisational identification, which opens for modification of existing boundaries. The study suggests that team activities that do not interfere with restrictions or regulations in the parent organisation could thrive in the team context, which supports Lindberg's (2002) notion that loose coupling within an organisation allows for external connections. Similarly, when team interactions are allowed to deepen and stabilize this also facilitates recategorization to the team. Thus, intensified interactions within the team have potential to develop new services across established boundaries.

Physical distance has a similar effect in limiting team and parent organisation interaction; actually, the very co-location of activities in the family care centre creates a proximity that allows, even compels daily interactions among team members. This proximity must, however, be deliberately utilized by team members through for instance regular team meetings and planning days. Since actors mainly perform separate service provision processes, it seems very im-

portant to access an arena where they may relate to each other, both professionally and personally. Also centre coordinators have an important role in encouraging regular and fruitful team interactions. So for new service provision processes to emerge and stabilize in the collaborative context, the presence of various *boundary platforms* seems crucial.

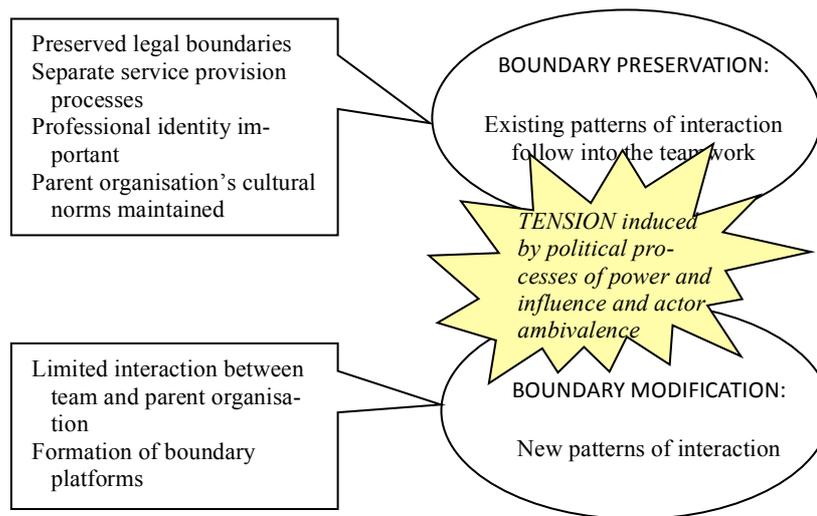
Boundary platforms produce fruitful meeting places through both material and human mechanisms such as regular team meetings and team coordinators. The concept has emerged empirically from this study. It goes beyond the kindred concepts of “boundary objects” and “boundary spanners”, respectively. Boundary objects, which foremost comprise observable artefacts (Star & Griesemer, 1989), and boundary spanners, which are human actors (Tushman & Scanlan, 1981), both mainly intends to traverse *social* boundaries; it is, however, not evident that this will allow for *cognitive* or *physical* boundaries to be exceeded. Boundary platforms, on the other hand, allow for actors to interact in novel ways and develop new forms of organising processes that are based upon changed perceptions of who one is and how to work. Boundary platforms could also be utilized to create reciprocal dependencies among previously pooled service provision processes (Thompson, 1967). Successful experiences of joint activities could set off a positive spiral of recategorization to a dual identity where team members combine their professional affiliation with a team-based social identity that also furnishes pride and self-esteem (van Knippenberg & van Leeuwen). Therefore, boundary platforms have the potential to exceed and modify both physical, social and mental boundaries.

The above discussion on forces towards boundary modification or boundary preservation, respectively, has been summarized in the figure below. Preserved legal boundaries, maintenance of organisational cultures and separate service provision processes imply that existing organising processes are sustained in the teamwork setting. On the other hand, disconnection of team activities from the parent organisations and the establishment of boundary platforms are the main mechanisms that contribute to develop new modes of human services delivery in accordance with the team’s integrative ambitions.

The figure also shows how a *tension* is induced between processes of boundary modification and boundary preservation and further maintained by political processes of power and influence where actors continuously negotiate and struggle to impose their cognitive views and behavioural norms. Diverging views on collaboration and power relationships among actors here become evident. Managerial actors mainly seem to work as to preserve existing organisational boundaries, but in allowing for team members to work autonomously in the teamwork setting they actually provide the basic requirements for interactions among team members to emerge at all. Professional actors may support forces in both directions, depending upon how important their organisational identity is for self-esteem and how predetermined their professional service production process is. Accordingly, the very meaning of “collaborating” could be interpreted differently, where some actors may view the co-location itself as collaboration whereas others wish to further integrate service production pro-

cesses. This mirrors differences between professions not only in terms of tasks and type of knowledge but also regarding degree of autonomy in defining the jurisdiction, as previously acknowledged by Abbott (1988). Continuous disagreement will contribute to maintain processes of negotiation where actors try to influence the organising processes from their respective point of view. It should also be noted that several actors in both cases seem to be torn between their previous and new affiliation and so actors might be genuinely *ambivalent* on whether to contribute to preservation or modification of boundaries. To conclude, it should be expected that attempts towards boundary modification will be continuously counteracted by forces of boundary preservation.

Figure 1. Mechanisms behind boundary preservation and boundary modification



Conclusions

Even though public policy makers as well as researchers have put forward collaboration between health care providers and professions as valuable for productivity and quality increase of human services, previous research has pointed towards the difficulties in attaining well-functioning integration. This study contributes with further explanations as to why these difficulties arise with a special focus on the multi-professional team context and the grass-root level perspective of involved professionals. This perspective has also allowed for development of knowledge on why and how collaboration could – possibly – be reached at.

This study suggests that multi-professional teamwork will evoke two simultaneously ongoing but counteracting forces: one towards boundary modification,

which facilitates fruitful interaction among professionals and in turn enables for new services development, and one towards boundary preservation, which contributes to upheld previously established ways of interacting and delivering services. In particular, the study's individualized research design has highlighted how professional actors cherish their professional identification; all the more when they are able (or obliged) to pursue previously established, pooled service provision processes also in the collaborative context. Existing boundaries between professions and services are thus continuously upheld. Furthermore, when interagency collaboration builds upon the assumption that established legal and economic boundaries between the involved parent organisations should not be altered, this will also contribute to preserve mental boundaries among team members.

On the other hand, disconnecting the multi-professional team from its parent organisations may be achieved through specialization of work between professionals in the parent organisation and the team, respectively, as well as by physical distance. Such disconnection will lead to reduced interaction between team members and parent organisation members that over time prepares for identity change of the individual professional and ensuing modification of not only physical and social but also mental boundaries among team members.

Furthermore, this study has contributed to the research vocabulary of collaboration by suggesting boundary platform as a new concept. Boundary platforms comprise any human or material artefact that creates meeting places for professionals and encourages interactions that manifest in individual recategorization towards a team identification. In particular, the concept intends to underscore that crossing of both physical, social *and* mental boundaries between the health care professionals that are directly involved in the collaborative attempt are decisive for the development of new, joint services provision.

Another important contribution from this study is that any deliberate attempt towards boundary modification will probably have to fight against the contradicting forces of boundary preservation that follow actors into the collaborative setting. A tension between forces of boundary modification and preservation will be induced and, as suggested in this research, continuously upheld due to actors having diverging – possibly also ambivalent – views regarding collaboration as well as due to a stubborn power hierarchy. Collaboration in health care becomes a persistent fight between these forces.

A number of practical implications could be drawn from these conclusions. Firstly, policy makers must acknowledge that moving professionals to common localities may be a necessary requisite for collaboration yet not enough for any deeper integration or development of joint services. Instead, continuous support must be provided, materially (financial resources) but preferably also symbolically (verbal praise). The former type of support is particularly required in order for managerial actors to be able to assist the team member in meeting expectations from both the parent organisation and the team. Collaboration requires personal and prolonged interaction, which must be taken into consideration when planning for team member's work situation. There is also a lesson to be learnt

for the professionals who choose (or are instructed) to work in the teamwork setting, namely to be open-minded towards other professional views and prepared to participate in the development of new services even if this involves exceeding one's immediate area of professional expertise. Only through the combined efforts of involved actors it is possible to cross or modify organisational, professional, and cultural boundaries and develop new modes of human services delivery.

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Notes

¹ For an overview of managerial restructuring efforts in health care services, see for example McKee et al. (2008).

² With the exception of one team member in Suburb centre, who declined to participate.