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Professionals' understanding of their responsibilities in the collaboration with family caregivers of older persons with mental health problems in Norway

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Abstract

Research has highlighted the importance of health and social care professionals' collaboration with family caregivers. In the field of mental healthcare, involvement of family members is perceived as beneficial to the recovery process of the care recipient. Furthermore, family care-giving is an essential part of elderly care. It is well documented that family members need support to prevent negative consequences of care-giving. Nevertheless, involvement of and support for family caregivers have not developed into a common practice, and research has identified professional barriers to collaboration with family caregivers in several areas. The aim of this study was to explore professionals' experiences of collaboration with family caregivers of older persons with mental health problems, and how they understood their responsibility towards families. We conducted three focus group interviews with 18 health and social care professionals working in community-based services, in three rural municipalities in Western Norway. The thematic analysis by Braun and Clarke guided the analysis. The findings in relation to the professionals' role and responsibility towards family caregivers are presented in three themes: family caregivers – a resource that needs support; a responsibility with unclear boundaries; and balancing different needs. Professionals recognised family caregivers' need for support and acknowledged the importance of family relationships. However, they experienced dilemmas in performing their dual responsibility of caring for the older care recipient as well as the family member, which they described as having unclear guidelines. They also experienced that they had insufficient knowledge to take on this responsibility. We argue that the exercising of discretion is essential for the professionals' responsibility, and that clarification of their responsibility is needed. We recommend a stronger focus in education on developing competence in the family perspective. Furthermore, the apportionment of professionals' responsibility needs to be formalised, especially when several services are involved in providing care.

KEYWORDS
care of elderly people, collaboration, family care-giving, focus group interviews, home care, mental health

1 | INTRODUCTION

The global shift towards an older population is a major concern in most Western countries and is leading to expectations of increased demand for health and care services, as well as shortages of skilled personnel. To meet these challenges, key collaborators for health and social care workers in community-based services are family caregivers, who represent a significant care resource in the field of mental healthcare (Carbonell et al., 2020) and in elderly care (Friedman et al., 2019).

The term ‘family caregiver’ refers to persons who provide care without being paid, with many family members having frequently played a significant care-giving role for many years. In Norway, family care-giving is described as an essential part of the care for older persons living at home (Rønning et al., 2009), despite being a public responsibility (Esping-Andersen, 2013). However, it is only in the last decade that the experiences and contributions of family caregivers have come to the fore in Norwegian politics, with an increased focus on the importance of involving and supporting family caregivers (Ministry of Health & Care Services, 2013). In addition, the responsibility of community-based services in supporting family caregivers with burdensome care tasks was regulated by law in 2017 (The Municipal Health & Care Services Act, 2011). Consequently, the professionals were given a dual responsibility: providing care for the person who is sick and supporting family caregivers.

The aim of this study is to explore health and social care professionals' experiences and understanding of their responsibility towards family caregivers of home-dwelling older persons with mental health problems.

Over the years, research has provided knowledge about the needs of persons with mental health problems and their family caregivers that has implications for professional practice. Initial research has explored the relationship between the clinical outcome in psychiatric patients and the quality of the relationship between the patient and their close family members. This particular measure of the family environment is referred to as Expressed Emotion (EE) (Wearden et al., 2000). Researchers have subsequently argued that incorporation of the principles of EE into clinical practice has a negative impact on professionals' attitudes towards family involvement (Furlong, 2001), but it has also been regarded as an important contribution to the development of psychoeducation therapy (Jeon, 2003).

There is now a shared understanding among professionals that persons with mental health problems benefit from living at home while receiving support, as it enables them to participate in community life. Being connected to family and friends has been identified as a strong predictor of better treatment outcomes (Amati et al., 2017; Glynn et al., 2006). Recovery-oriented care (Davidson et al., 2005) and network-centred approaches (Seikkula et al., 2003) are examples of theoretical perspectives that include family and social networks in the recovery process.

In the field of mental healthcare, professionals describe their work aimed at family members as a spectrum: from the provision of general information to more specialised interventions such as family psychoeducation, consultation and therapy (Eassom et al., 2014). Family involvement in care planning, which includes making joint decisions or direct involvement in the care plan, is also a part of this spectrum (Doody et al., 2017).

Another major field of research focuses on the negative consequences of care-giving for the family member, referred to as the concept of burden. The initial focus was on caregivers of patients with dementia or schizophrenia (Jeon, 2003), but several other patient groups have gradually been included. It is now well documented that care-giving can lead to poorer mental and physical health for the family member, in addition to reduced quality of life (Schulz et al., 2020; van Campen et al., 2013). To mitigate these negative consequences, several interventions to support family caregivers are described, such as psychoeducation, practical help and respite, emotional support and a shared approach to the care (Anker-Hansen et al., 2018; Schulz et al., 2020).

Despite the knowledge that family involvement and support could benefit both the care recipient and the family caregiver, professionals' collaboration with families has not developed into a common practice. Qualitative and quantitative studies have investigated professionals' attitudes to and perceptions of barriers to collaboration with family caregivers (Benzein et al., 2008; Eassom et al., 2014; Goodwin & Happell, 2007; Hjärthag et al., 2017; Kim & Salyers, 2008; Landeweer et al., 2017). One of the most frequently reported barriers was professionals' descriptions of the conflict between the patient's right to confidentiality and the family's right to information. Furthermore, colleagues and managers did not value or prioritise family involvement, and family work was considered to be of secondary importance or optional. There were also organisational

What is known about this topic

- Family caregivers' contribution is an essential part of the total care resource; however, caring could have negative consequences for the health of the family members.
- Collaboration between professionals and family caregivers is not standard, but could benefit care recipients, family caregivers and community-based services.

What this paper adds

- Health and social care professionals acknowledge family caregivers' contribution and their need for support; however, involvement of and support for family caregivers can give rise to dilemmas.
- The professionals find that they do not have the knowledge or guidelines to meet the dilemmas.
- Collaboration with family caregivers of older persons with mental health problems is especially challenging due to the unclear apportionment of responsibilities when several services are involved in providing care.

obstacles, such as a lack of a system, time constraints, resource shortages and professionals' lack of skills to engage meaningfully in the patient and family caregiver relationships (Eassom et al., 2014).

People with mental health problems living in rural areas may face challenges such as limited access to mental health specialists and to professionals with sufficient mental health training (Gamm et al., 2010; Sharma, 2020). In addition, the coordination among healthcare providers may not always be adequate. In Norway, many community-based services are divided into home healthcare and mental healthcare. Home-dwelling older persons with mental health problems are mostly under the care of home healthcare (McCormack & Skatvedt, 2017; Skatvedt et al., 2015), and according to Skatvedt et al. (2015), the professionals express insecurity regarding their own skills in caring for older persons with mental health problems and their family.

Although several aspects of collaboration have been explored, few studies have focused on family caregivers of older persons with mental health problems (Hengelaar et al., 2018). Knowledge about the involvement of and support for family caregivers of older persons with mental health problems is therefore scarce. Consequently, we posed the following research questions: What are home healthcare staff and mental healthcare staff's experiences of collaborating with family caregivers of older persons with mental health problems? How do they understand their professional responsibility towards the families?

2 | METHOD

We conducted focus group interviews, where the intention was to obtain knowledge of health and social care professionals' experiences, opinions and interpretations (Krueger & Casey, 2015). Braun and Clarke (2006) 6-phase approach to latent thematic analysis guided the analysis.

2.1 | Setting and study participants

We performed the study in three rural municipalities in Western Norway. The inclusion criterion for participation was professionals working in direct contact with older persons with mental health problems, living at home. Based on findings from earlier research (McCormack & Skatvedt, 2017; Skatvedt et al., 2015) and advice from persons working in community-based services locally, the study included professionals from mental healthcare as well as home healthcare services. To prevent asymmetric power relations between the participants, they had to have a minimum of a bachelor's degree in health or social care, and professionals in managerial positions were excluded. Furthermore, we excluded professionals working with persons with dementia because this patient group is mostly under the care of the home healthcare services.

The recruitment of participants began in February 2018. First, we contacted the mangers of health and social care services in five municipalities. Managers from three municipalities accepted the invitation and assisted in the recruiting process by distributing the invitation letters. Reasons for not participating were 'too heavy workload' and 'few older persons cared for by mental healthcare services. Eighteen professionals agreed to participate voluntarily.

2.2 | Data collection

We collected data from three focus group interviews held in June 2018. Each interview had six participants: three professionals from mental healthcare services and three from home healthcare services. We conducted the interviews at the participants' workplace in undisturbed surroundings.

Based on earlier research, we developed a semi-structured interview guide with open- ended questions, which was tested in a pilot interview with a mental healthcare nurse from community-based services (Kallio et al., 2016). After testing, we made minor changes to the formulation of questions. The questions focused on the professionals' assessments of family caregivers' contribution, experiences of collaboration with family caregivers, involvement of and support given to family caregivers and assessments of professional and organisational prerequisites for collaboration.

All three interviews lasted about 120 min, which included providing information on what participation entailed and a short midway break. The focus group discussions were audio taped. In the interview setting, the first author moderated the discussion and a co- moderator assisted with observing non-verbal communication, the dynamic in the group and asking clarifying questions at the end of the interview. Focus group 2 consisted of participants with a variety of experiences and opinions regarding collaboration with family caregivers, and discussion mostly took place without the involvement of the moderator. In contrast, the experiences of participants in focus groups 1 and 3 were scarce, and the moderator had a more active role in questioning and guiding the discussion. On the basis of the variations in participants' experiences, we considered these three interviews to be satisfactory.

2.3 | Analysis

We followed the 6-phase latent thematic analysis described by Braun and Clarke (2006). The analysis started during the data collection, and after each interview, the moderator and co-moderator discussed verbal and non-verbal communication and the dynamic in the group. The first author transcribed the interviews, reproducing all spoken words and sounds, including laughter, hesitations, pauses and strong emphases. In the presentation of findings, we removed words and sounds that were not essential for understanding the overall meaning of the quotes. In the first phase of analysis, all transcribed interviews were read through, and patterns and meaning were sought across the entire data set. The second phase consisted of inductive coding, focusing on producing descriptive codes that represented the participants' meaning. We used the software program NVivo (NVivo, 2018) to manage this phase of the analysis. Furthermore, we sorted the codes into potential themes and subthemes. The final phases of the analysis process consisted of moving back and forth between defining and naming themes, writing the report and reviewing themes in relation to the coded data and the entire data set. All three authors read the transcribed interviews and participated in all phases of the analysis to ensure a nuanced analysis.

2.4 | Ethics

Ethical approval was obtained from the Norwegian Centre for Research Data (approval number 58265). We obtained written informed consent from each participant and informed them that they could withdraw at any time. Confidentiality regarding the collected data was safeguarded through storage on a computer in double password-protected files. In reporting the findings, all data were anonymised so as not to expose any personal details about the participants or persons not present, such as the care recipients and family caregivers. In addition, personal details about persons not present were anonymised during the focus group discussion.

3 | FINDINGS

In total, 18 professionals participated, five had a social science qualification and 13 were nurses. The participants each had between 5 and 40 years of work experience from health and social care services. One of the participants worked both as a manager and in direct contact with older persons. Table 1 shows the characteristics of the participants.

We found that analysis of data relating to health and social care professionals' experiences of collaboration and understandings of responsibility towards family caregivers produced three themes which we named: a resource that needs support, a responsibility with unclear boundaries and balancing different needs.

When initiating services, the professionals' first course of action was to identify the person with whom they were to collaborate to safeguard the care recipient's right to confidentiality and self-determination. The collaborating party was, in most cases, a family member, who the care recipient had stated when applying for services.

3.1 | Family caregivers – A resource that needs support

The participants assessed family caregiver's contribution of social support, as provided by someone who cares for and makes the older person feel safe, as a very valuable resource for both the older person and for the community-based services. A mental healthcare staff member (FG 2) described this contribution as follows:

> The fact they (family caregivers) care for, are fond of and have the older person's best interest at heart is a strength and a resource. And we have to play to this strength when meeting the care recipient.

Information provided by family caregivers was an important consideration for professionals when planning for the older person's care needs. Based on their continuous observations and lifelong experiences with the older person, they could provide essential information about changes in the health situation and make suggestions for care and treatment. One home healthcare staff member (FG 2) said:

> .. they give support, take away some of the loneliness, and when it comes to medications, they are a great resource, they are in the same house and are present round the clock, and they can observe changes.

TABLE 1 Characteristics of the participants

Characteristic	Focus group 1	Focus group 2	Focus group 3
Gender			
Women	5	5	6
Men	1	1	
Education			
Nurse	5	4	4
Social Worker	1		1
Child welfare			1
Occupational therapy		1	
Other health and social related courses		1	
Years of experience	14–21	5–24	15–40

The participants were aware that the factors that made family caregivers a resource also put them at risk of the burden of experiencing negative consequences of being a family caregiver. According to participants' experiences, some of the family caregivers had poorer mental or physical health as a result of providing care, and some had to withdraw from the care-giving role. Participants assessed the care-giving as especially burdensome for family members who provided care round the clock and for those who had provided care over a long period of time. In addition, they observed that family caregivers found it difficult to understand and relate to the behaviour of the person who was sick. All of the participants were aware of the family caregiver's need for support themselves; in particular, they needed information about mental health problems and treatment, and they needed respite.

3.2 | A responsibility with unclear boundaries

The participants mostly described their experiences of collaboration with family caregivers as scarce. Participants had various opinions on their responsibility, with some expressing explicit involvement of and support for family caregivers as their responsibility. This particularly applied to situations when they met family caregivers face-to-face and the care recipient and the family caregiver had a good relationship. One mental healthcare participant (FG 2) expressed:

> It is a basic attitude to care for the family member in situations when you come home to the care recipient and the family member is present, and they have a good relationship

Furthermore, participants described their responsibility being to build a trusting relationship, including listening to the knowledge of family caregivers, acknowledging the family caregiver as a person with their own needs and opinions and recognising their contribution. Trust was described as a premise for family caregivers contacting community-based services. One home healthcare participant (FG 1) expressed:

> .. they must be seen and asked how they are doing. And many times, it is important that there is some continuity, so they can get to know us and feel confident with us. And the more they get to know you, the more questions they ask.

Professionals' experiences of responsibility towards family caregivers were also expressed in relation to prioritising time in a busy workday for involvement and support. One home healthcare participant (FG 1) stated:

> .. in a way, no one says ‘I haven't got time to talk to you’, you go to great lengths to give them time, or you agree to talk another day or with someone else.

In contrast to participants who defined involvement of and support for family caregivers as their responsibility, there were others who considered this not to be the responsibility of health and social care professionals. They described their responsibility as solely to provide information in situations when the older person's health condition deteriorated. The participants perceived there to be a lack of acceptance for prioritising time to support them, and they rarely discussed the subject of family caregivers in the workplace. A lack of shared professional understanding and a lack of experience were reflected in the interview setting. One mental healthcare participant (FG 3) asked:

> .. maybe the conclusion is that we don't have much contact with family caregivers, since we don't really talk about them?

Most participants described that the services lacked a shared professional understanding and organisational standards of responsibility, which were considered important conditions for the collaboration with family caregivers. A need for more knowledge on how to provide care and how to collaborate with both the older person and the family member was common among the participants. One mental healthcare participant (FG 1) noted:

> .. but there is still too little focus on how to relate to family caregivers, what we can offer. And, again it is individual, depending on the care recipient and his symptoms...

Furthermore, the participants experienced a lack of guidelines on how to involve and support family caregivers. Consequently, the practice of involving and supporting family caregivers was referred to as unpredictable in relation to who received support. One home healthcare participant (FG 1) observed:

> We are not good enough, or there is no system, then it often becomes random, where someone gets (support), and others don't

In particular, participants discussed two challenges. First, they were unsure about who was responsible for involving and supporting family caregivers when the care recipient was under the care of both services. One home healthcare participant (FG 3) said:

> ..I thought, if someone was to have contact with a family caregiver, it would be you (mental healthcare staff), and if you have little contact with them, then the contact will be very scarce.

Second, they described how the approaches to involving and supporting family caregivers for older persons with mental health problems differed from those for caregivers of younger persons. When reflecting on these differences, participants expressed a perception that family caregivers of older persons only wanted involvement and support in the form of information. In some cases, not involving family caregivers was understood as a way of taking care of family caregivers by protecting them from burdensome care tasks. Furthermore, mental healthcare participants spoke of guidelines that facilitated involvement of family caregivers, in the form of interdisciplinary collaboration meetings and the preparation of individual plans. However, they had little experience in using such approaches when providing care for older persons and their family caregivers, which they linked to different treatment goals and the fact that the older care recipients did not want an individual plan.

3.3 | Balancing different needs

Health and social care professional' need for guidance and knowledge was expressed through participants' descriptions of dilemmas, and how these dilemmas could lead to less involvement of and support for family caregivers. All of the participants experienced dilemmas in sharing information. However, this mostly concerned mental healthcare participants, because they found it difficult to address family caregivers' need for information when the care recipient did not consent. Dilemmas arose when they had to balance their responsibility to provide general information, which they described as not bound by confidentiality, with their responsibility to protect the care recipient's right to self-determination. Furthermore, listening to family caregivers' experiences could lead to dilemmas, especially if the older person and their family member had different understandings of the situation. Mental healthcare participants experienced dilemmas in balancing the older person's subjective experiences, the family caregiver's information and their own observations. One mental healthcare participant (FG 2) described:

> family caregivers have a lot of knowledge, through a long life, which can be of importance to us, for example, about medication. And then of most importance is the patient's own personal experiences. Nevertheless, you can receive useful information about how things have changed… what they (family caregivers) have seen and heard.

In some situations, family caregivers were not considered a resource; on the contrary, their care-giving was understood as making the older person's health worse. The participants experienced dilemmas in balancing the different needs when providing care for both parties. Some chose to provide guidance on how to improve communication between the family caregiver and the older person, or they chose not to focus on the family caregiver. One mental healthcare participant (FG 2) observed:

> ..and considering that maybe the spouse is part of the problem, making the illness worse, then I can focus less on the family caregiver because I think, okay, I'm here for the care recipient.

As the quotes show, participants sometimes found the responsibility to be challenging when balancing the needs of the two parties. Furthermore, they worried that their choice of action could have an adverse effect on the collaborative relationship between all parties.

4 | DISCUSSION

The aim of this study was to explore health and social care professionals' experiences and understanding of their responsibility towards family caregivers of older persons with mental health problems. Our analysis illustrated that professionals acknowledge the family's extensive contribution and had a positive attitude toward this. However, participants' descriptions of their professional responsibility regarding the collaboration with family caregivers varied considerably. They perceived the involvement of, and support for, family caregivers as challenging, especially when balancing between the different needs of the older person and the family caregiver.

4.1 | Variations in involvement

Our analysis illustrated that the professionals' role in the collaboration with family caregivers varied considerably, a result which is in line with findings of international studies (van de Bovenkamp & Trappenburg, 2012; Zegwaard et al., 2015). Variations in involvement may be a reflection of professionals' sensitivity and adaptation to differences in the older person's and family caregiver's needs in different contexts. For example, participants described being sensitive and adapting to the different needs as central to developing mutual trust and understanding. These qualities have been highlighted as essential for collaboration, from the perspective of both professionals and caregivers (Hjärthag et al., 2017; Jeon, 2004; Landeweer, 2018; McCann & Bamberg, 2016; Ris et al., 2019; Zegwaard et al., 2017). However, our analysis also illustrated that most of the participants' experiences of collaboration with family caregivers were scarce, which may indicate that the involvement of and support for family caregivers is not a prioritised task. This lack of priority may be due to unclear guidelines, lack of a shared professional understanding and inadequate resources.

4.2 | The role of exercising discretion – A continuous process with dilemmas

The theory of street-level bureaucracy by Lipsky (1980/2010) can help to develop understanding of health and social care professionals' working behaviour and provide a background for discussing the conditions for the professionals and how these affect the care of patients and family caregivers (Cooper et al., 2015). According to Lipsky, street-level bureaucrats are responsible for the delivery of policy through their engagement with the public, and their work is characterised by substantial discretion. Their work can be difficult to perform in line with the ideals of the services, partly because of inadequate resources, the goals are imprecise and that expectations could be contradictory and cause role ambiguity. In this perspective, the professionals can, like a street-level bureaucrat, be torn between adhering to the general guidelines for community-based services for older persons and supporting their family caregivers, as well as the requirement for efficiency. Our analysis showed that some participants found it difficult to prioritise time to involve and support family caregivers. We assume that prioritising time to support family caregivers was perceived as a dilemma because it resulted in less time to care for the mental, physical and somatic problems of the older person. As a consequence, they chose not to collaborate with family caregivers. In the light of the Lipsky's (1980/2010) theory, such an approach could be understood as professionals developing a pattern of practice to resolve the dilemma of inadequate resources. A response could be to modify their concept of responsibility and simplify their tasks, to make them manageable. In doing so, street-level bureaucrats can shape the policy through their exercising of discretion. A notable finding in this study is that participants who defined the collaboration with family caregivers as their responsibility did not regard lack of time as a barrier, but rather spoke of how they made time.

4.3 | Unclear guidelines and lack of a shared professional understanding

A consistent finding was that participants acknowledged the importance of family relationships and recognised family caregivers' need for support. However, they perceived the guidelines on their responsibility towards family caregivers to be unclear. A contributing explanation for the professionals' scarce experiences of collaboration may be related to dilemmas concerning conflicting expectations and role ambiguity (Lipsky, 1980/2010). In practice, participants found the policy requirements and service ideals concerning their dual responsibility to be conflicting. Participants expressed that such dilemmas could lead to less involvement of and support for family caregivers. They found it particularly challenging to balance the care recipients' right to privacy and confidentiality, and the family caregivers' right to information. National and international research underpins our findings regarding the description of professionals' experiences of conflicting standards in task performance (Anker-Hansen et al., 2019; Eassom et al., 2014; Hengelaar et al., 2018; Landeweer et al., 2017; Weimand et al., 2013).

In addition, the participants' descriptions of their responsibility towards family caregivers illustrated the absence of a shared professional understanding. This result may reflect the family perspective being imprecise in relation to the goals of the service and in education. It is reasonable to assume that professionals' lack of attention to the collaboration with family caregivers will affect how professionals prioritise and determine who is qualified to receive their services, which is a responsibility of the street-level bureaucrat (Lipsky, 1980/2010). Previous research has pointed to the strong focus on the individual, both in Western society (Furlong, 2001; Landeweer, 2018) and in the medical paradigm (Landeweer et al., 2017; Weimand et al., 2013), as an explanation of why the family perspective has received less attention. Researchers in the field of mental healthcare have argued for a shift from an individualised focus to approaches involving collaboration with the care recipient, families and communities, such as a network-centred approach (Seikkula et al., 2003) and a recovery model (Glynn et al., 2006; Tew et al., 2012). Such approaches can help clarify the professional's role and responsibility towards family caregivers, and as argued above, provide guidance on their prioritising of tasks. However, theoretical approaches may not resolve the dilemma of contradictory expectations. Although relationships and connectedness are important components of recovery-oriented care, the model can be regarded as individualistic (Price-Robertson et al., 2017) because the ethical principal of autonomy, and the care recipient's empowerment and control over their life is central in the recovery model.

This study has provided nuances and depth to previous research on dilemmas of the professionals' responsibility towards family caregivers. Of particular note is the findings indicating that the collaboration with family caregivers of older persons with mental health problems is especially challenging. For example, participants described being familiar with professional approaches that facilitated family involvement; however, they had little experience of using this approach when providing care for older persons with mental health problems. Furthermore, the complexity of older persons' health problems can result in the need for support from several community-based services. Unlike many other studies, our study included staff from both home healthcare and mental healthcare, and consequently revealed that it was particularly challenging to know who was responsible for involving and supporting family caregivers.

5 | STRENGTHS AND LIMITATIONS

We found that the use of focus group interviews brought to light a manifold of experiences and opinions and were well suited for the purpose of the study. For participants who had little experience of collaborating with family caregivers in particular, the group discussion gave them the opportunity to respond to other participants' reflections and recall situations from their own practice. However, divergent opinions can be difficult to address in a group discussion. Another methodological strength is that all researchers participated in critical discussion during the analysis process, which strengthened the trustworthiness.

A limitation of our research is that the study was performed in rural and small municipalities, all within one county. The organisation of the services and competence may be different in larger, more centrally located municipalities. However, based on our findings, previous research and the absence of a national standard for collaboration with family caregivers, it is reasonable to assume that the dilemmas discussed may also arise in other municipalities where the community-based services are organised differently. Furthermore, all the participants had a bachelor's degree. As a result, this study has not captured the experiences and opinions of professionals with a vocational education, who also form a large part of the services.

6 | CONCLUSION AND IMPLICATIONS

The dual responsibility of caring for the care recipient and the family member can be a complex professional situation and one that can create significant tension between all parties. We propose that the deliberations on whom to involve and how to involve family caregivers should take the form of an ongoing dialogue between the group of collaborating professionals, the care recipient and the family caregivers. In this work, we argue that the exercising of discretion is central to the professionals' responsibility towards family caregivers to adapt the collaboration to individual needs. However, professionals need to strengthen their competence in relation to clarifying their responsibility. First, we recommend more focus on the family perspective in education. Second, the apportionment of responsibility for involving and supporting family caregivers, especially when several services are involved, needs to be formalised.

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CONFLICT OF INTEREST

No conflict of interest.

AUTHOR CONTRIBUTIONS

All three authors have participated in the planning of the study and data analysis. The first author performed the data collection, and the third author participated in the first interview. The first author drafted the manuscript, and all authors contributed to the final manuscript.

ETHICAL APPROVAL

Permission was obtained from the Norwegian Centre for Research Data, approval number 58265.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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