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# Support to 'non-clients': care managers' role in direct and indirect carer support

## Stöd till 'icke-klienter': biståndshandläggarnas roll i direkt och indirekt anhörigstöd

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### ABSTRACT

Social service provision in Europe has increasingly incorporated informal carers. Consequently, these carers are now included within the scope of all social workers, including care managers. Most support for carers is indirect support, where opportunities for respite are channelled through the care receiver's needs assessment. This approach highlights the unique role of care managers providing carer support as they balance their public task directed towards clients with the concurrent policy-driven expectation to support carers. The aim of this article is to explore how care managers, as street-level bureaucrats, 'make' carer support policy on the ground. Using systematic text condensation of 10 qualitative interviews with care managers in Sweden, we present three themes to understand care managers' experiences. Care managers work '*Hand-in-hand*' and '*hands on*' with carers, carers are *within, yet outside one's scope of work*, and there are *possibilities and practices towards a carer perspective*. Following Lipsky's dictum that street-level bureaucrats' actions effectively 'become' the public policy they carry out, our results highlight care managers' possibilities and challenges in shaping what direct and indirect carer support looks like on the ground.

### SVENSKA

Socialtjänsterna i Europa har i allt högre grad omfamnat informella omsorgsgivare. Anhöriga blir följaktligen en del av socialarbetarnas ansvar, inklusive biståndshandläggarnas arbete. Merparten av stöd till anhöriga består av indirekt stöd, som genom insatser till den omsorgsbehövande möjliggör avlastning. Detta aktualiserar biståndshandläggarnas unika roll då de balanserar skyldigheten mot sina klienter med ett ansvar att stödja anhöriga. Syftet med denna artikel är att undersöka hur biståndshandläggare, som gräsrotsbyråkrater, 'gör' policyn om anhörigstöd. Den belyser också biståndshandläggarnas möjligheter och utmaningar i att stödja anhöriga. Med hjälp av systematisk textkondensering av 10 kvalitativa intervjuer med biståndshandläggare presenterar vi tre teman för att förstå deras erfarenheter. Biståndshandläggare arbetar *hand-i-hand och*

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*hands-on* med anhöriga, anhöriga är *inom*, *men utanför deras arbete*, och vi visar möjligheter och genomförande av ett anhörigperspektiv. Efter Lipskys talesätt att gräsrotsbyråkrater ‘gör policy’, belyser våra resultat behovet av att ytterligare stärka biståndshandläggare i sin roll för att kunna ge formellt och informellt stöd till anhöriga. Biståndshandläggare har en viktig roll i hur policy för anhörigstöd omsätts i praktiken.

## Introduction

Policy developments in Europe have incorporated the needs of informal carers in social services in the past decades (Zigante, 2018). Consequently, carer support is now increasingly within the scope of concern of all social workers, including care managers. Care managers – sometimes also called needs assessors or case managers – are social workers in adult social work that assess individual needs and decide the type of social care and services that service applicants are eligible for, within the frame of policies and available resources (Dunér & Nordström, 2006). Social services can serve as necessary respite for informal carers, but as previous literature indicates, carers are also paradoxically ‘invisible’ in the assessment and management of these services. For example, carers’ needs are still seldom explored in meetings with social workers, and carers often feel that they need to prove their worthiness to care managers to receive respite services (McPherson et al., 2014; McSwiggan et al., 2017). Accordingly, the need to integrate the perspective of carers in care management has been emphasised (Cree et al., 2015). Care managers, however, often feel conflicted about informal carers’ involvement in care receivers’ needs assessments (Janlöv et al., 2011). They also tend to underestimate their own role in carer support and prefer to refer carers to counselors and other professionals (Nilsson et al., 2022).

## Aim

Sweden is one of three European countries (besides the UK and Netherlands) where there is a national policy to support carers across the board of social care services (Courtin et al., 2014). Within this context, the aim of this study was to illuminate the experiences, possibilities and challenges of care managers in ‘making’ carer support policy as street-level bureaucrats.

## Background

### *Street-level bureaucrats implement and ‘make’ policy*

The concept of a street-level bureaucrat was coined by Michael Lipsky in the 1980s to illustrate the intermediary position of government workers, such as care managers, between the state and citizens (Lipsky, 2010). Street-level bureaucrats, he posited, were the ‘human face’ of policy, as they implement laws in face-to-face interaction with citizens.

Zacka (2017, pp. 23–24) outlines three interconnected traits of street-level bureaucrats. Firstly, they are public service employees at the front line of government. Secondly, they are representatives of the state working directly with the public. Finally, as they implement policy on a case-to-case basis, they also use practical judgement and are thereby vested with a large amount of professional discretion to ‘translate’ policy to practice (Hupe, 2019). Consequently, street-level bureaucrats influence the shape of policy in day-to-day encounters, even though they do not write policies themselves. As Lipsky illuminates, ‘street-level bureaucrats indeed “make” policy in the sense that their separate discretionary and unsanctioned behaviours add up to patterned agency behaviour overall. But they only do so in the context of broad policy structures of which their decisions are a part’ (Lipsky, 2010, p. 211).

## The carer perspective

In Sweden, the policy intention of including carers in the purview of care managers is not new. In 2009, the statute to 'offer assistance to aid persons caring for a relative who has a long-term illness, is elderly, or has a disability' was included in the Social Services Act (Act 2001:453, Ch. 5 10S), which is the framework law followed by care managers. The following year, the National Board of Health and Welfare circulated a memo addressed to care managers (among others) emphasising the importance of a carer perspective in the needs assessment process (Socialstyrelsen, 2010). This policy was echoed in other documents highlighting the carer perspective when assessing, planning, and carrying out decisions about welfare services (Socialstyrelsen, 2020). Recently, carer support policy has also gained renewed traction through the establishment of a National Carer Strategy in 2022 and national recommendations to boost a carer perspective in health – and social care (Socialdepartamentet, 2022).

Pertinent to care managers' possibilities in providing carer support is the classic distinction between *direct* and *indirect carer support* (Brimblecombe et al., 2018; Jegermalm & Torgé, 2023). *Direct* support is forms of support that caregivers themselves are entitled to without needs assessment, such as counselling, peer support, and training opportunities. *Indirect* support, on the other hand, is a result of social care services to the care receiver, that eases burden for the carer. One important difference is that while carers are the clients of *direct* support, the provision of *indirect* support is channelled through another person's (i.e. the care receiver's) needs assessment (Courtin et al., 2014; Zigante, 2018). Care managers use professional judgement when assessing care receivers' eligibility for services and, in effect, forms of indirect support available to the carer. However, while deciding suitable interventions, they are also constrained by standardised welfare services (Wittberg & Larsson, 2021).

The concept of the 'carer perspective' is also only ultimately concretised in care managers' direct contact with individuals. The carer perspective is only loosely defined in policy text and is taken to mean a work ethic that considers the needs, concerns, resources, and expertise of carers. However, examples of actions are proposed in policy such as: listening to and acknowledging carers, meeting carers with respect, collaborating with carers, offering carers the opportunity to participate in needs assessments, taking account of carers' opinions in the care management process, exploring carers' needs and informing them about available carer support, continuity of contact and following up on support services (Socialstyrelsen, 2013). In addition, street-level bureaucrats' own understanding of their role shapes what they try to achieve in contact with carers (Olaison et al., 2018). Research shows that care managers agree on the importance of supporting, listening to, and identifying needs of carers, but often do not realise their actual role in carer support (Nilsson et al., 2022; Nilsson et al., 2023).

## Materials and methods

### Study design

This article is a part of a three-part research project on informal carers' and welfare professionals' views of carer support. The project was conducted in two administrative counties in Sweden and builds on qualitative and quantitative data collected from informal carers, family care consultants and care managers. For the qualitative substudy, purposive sampling was used to recruit 20 informal carers and 20 welfare professionals (10 family care consultants and 10 care managers) for qualitative semi-structured interviews. For this article, we only used the interviews with the care managers. The project design was approved by the Swedish Ethical Review Authority (Dnr 2021-03393).

### Sampling

To be included in the study, care managers had to work with needs assessments in old age care or disability services and have at least three years' experience in that role. Written information about

the study was given to the municipal heads of Social Services, who distributed the information. Care managers who fulfilled the purposive sampling criteria and wished to participate contacted the researchers directly. Six participants were self-selected in this way. To reach 10 participants, we subsequently used snowball sampling by asking participants to recommend other colleagues. The recruitment stopped when 10 care managers were interviewed. Five care managers worked in old age care, one was a needs assessor in disability services only, and four worked with services for both groups.

### **Data collection**

The interviews were conducted in February 2022 when COVID-19 restrictions were still in place or newly lifted in Sweden. For this reason, the interviews were conducted by phone or video call, with most participants preferring video calls. The interviews were conducted either by CJT, with a background in Gerontology, or PN, with a background in Social Work. Both have extensive experience of conducting interviews. A semi-structured interview guide was used. The interviews lasted 60–90 minutes, were recorded through an audio recorder (video not included) and transcribed verbatim with names replaced by pseudonyms.

### **Analysis**

The interviews were analysed using systematic text condensation (STC) as outlined by Malterud (2012). STC shares many characteristics with other qualitative analysis methods such as qualitative content analysis, in particular the coding of meaningful units of data, abstraction, and thematisation. It is a pragmatic approach that reflects how many researchers work with theme development, where the researcher wants to stay close to participants' experiences and has an explorative aim but is also influenced by an overarching research focus (Malterud, 2012).

First, the researchers created a total impression of the data by reading the interview transcripts carefully. The purpose of this step is to form a list of preliminary themes and issues that are possible starting points for organising the data. These themes were refined through discussion in the research group and were further systematized in the next steps of analysis.

Secondly, in coding, the material was read again to identify passages of text that contain information related to the questions at hand. Meaningful units were extracted to a Word document. The first author noted features of the passages and labelled them with codes. Codes were further revised and adjusted as the coding work progressed. Discussion in the research team led to further fine-tuning of codes and further ensured that codes were appropriate.

Thirdly, through condensation, categories were built from sets of codes. These helped form an analytical focus of attention, but also helped demonstrate diversity in the data. The aim of this step was to say something about patterns in the data. Condensation is not quantification of codes, but a transformation of the data through selection and paraphrase, with codes being subsumed in a larger pattern and so on (Miles et al., 2013).

Finally, the fourth and final step involved synthesising the findings and presenting them as a meaningful story with the help of labels that communicate the researcher's interpretations. To help guide the reader, quotations from the interviews were selected to illustrate the findings.

The analysis led to three themes. Care managers describe working *'hand-in-hand'* and *'hands on'* with carers, carers are felt to be *within, yet outside one's scope of work*, and *possibilities and practices* to work towards a carer perspective were found.

## **Results**

### ***'Hand-in-hand'* and *'hands-on'***

From the outset, all participants conveyed that while their duty is primarily towards the service applicants, contact with carers was inevitable and always present in their work. Regardless of which area

the participants worked in, they said that informal carers often initiated contact with social services on behalf of care receivers. Less often, care receivers also initiated contact when they would rather have formal care than informal help.

Communicating with carers often continued as part of the needs assessment process. Many indicated that they relied on the information given by carers to make correct assessments and ascertain the client's situation. They also relied on carers' involvement in other ways, for example when planning home care upon hospital discharge, or when clients had limited physical or cognitive abilities to book meetings with social workers.

Reliance on carers was illustrated by expressions that they 'worked together' with carers and had to have carers 'on board'. As these examples show, contact with carers was regarded as a prerequisite for assessment and delivery of services to the care receiver:

Relatives are so important to have on board for the legal certainty [of the decisions]. Because they know the person. They can tell us about how the situation was before, and what help they had to give. It's very good to have them on board in the needs assessment to get as broad a picture as possible. (Dina)

It's very common that we have contact with relatives about the care receiver. Maybe it's because our clients have a hard time establishing contact themselves. Often, it is the relatives that represent the interests of the older person, do all the calling, fill in the application forms – even if technically the client is the one applying. (Isak)

Working with carers, as in the examples above, is reminiscent of the model of carers as *co-workers*, where the partnership between carer and professional is cooperative and focused on the care receiver (See Twigg, 1989). Furthermore, as Nilsson (2019) argues, valuing the carer's participation and knowledge can be also regarded as a kind of carer support. Indeed, contrary from perceiving carers merely as instrumental resources, the participants described how gaining insight into the clients' situation could not be disentangled from empathising with the carers' situation. Participants thus described a simultaneous process where the carers – with which they work *hand-in-hand* to make informed decisions – also emerged as their own subjects requiring the care managers' *hands-on* help. One participant underlined that as the carer's first contact person, care managers inevitably become 'the go-to person' for carers:

I think I have as many different roles [in relation to carers] as there are cases. Some carers make contact because they feel worried. An older relative might have fallen and gotten a fracture or has ailing health. My role is to support and say, "okay, we can set up home help service." Sometimes, carers call to inform me about whether the service has worked well or not, and if we could do something about it. I become the hub and the go-to person. In some cases where there is dementia or extensive illness, I'm also a kind of a support to lean on. You become a person that they come to for a solution because they don't know what to do. There is a lot of grief, a lot of feelings that they want to talk about. And desperation too, because, well, the care receiver is sick and needs a lot of help. (Gun)

Like this participant, others described managing carers' emotions in their everyday work. Some described phone calls with carers in crisis and, and 'coming close' to the carers' feelings. Because listening to carers' concerns is often associated with direct carer support provided by counsellors, a striking finding from our interviews is how the proximity of care managers allowed them to provide *hands-on* carer support in this way. Because they worked *hand-in-hand* with the care receiver's situation, there is an existing relationship, common knowledge and trust that can be built on:

As care manager, I assess the needs of the client. I do the home visits. I make most of the decisions. So, it is natural that carers turn to me to talk. I have the mandate to make the decision and as assessor, we've already established a relationship. To take in another extra person [a counsellor or family care consultant], who doesn't know all the details and can't inform them about the decision, I think many find that too vague. Of course, they should have help if they feel that they are breaking apart. But often I find that it is about frustration about not knowing what will happen. And they want to talk to someone who can do something about it, or someone they already have an existing contact with. That's my point of view, that they would rather talk with me. But of course, there are some who say they want contact with a family care consultant. I can also suggest that they contact a counsellor. (Hanna)

Not all participants believed that they should give *hands-on* help to carers. There were a few participants in our interviews that drew a clear line between their responsibility for clients and responsibility for carers, which can be interpreted to be a more *hands-off* attitude and one that highlights the ambiguity of the carer as a non-client:

[Counselling carers] is not in my role. It's nothing that I do or wish to do. I try in these conversations to get them to seek help where they can get help. Because I can't help them with that. / ... / I sometimes wish that there would be some kind of possibility to give direct help. To take the carer by the hand, go to the health care clinic and say: "Here's your psychologist!" [laughs]. We can do that with clients – to help them hands-on because that person is a client, and they don't have the energy to do things by themselves. For carers, you could do that if you wanted to. Nothing is stopping us from doing that. But it would be to treat relatives as clients, and that's not what we're meant to do. (Frida).

### ***Within, yet outside their scope***

Regardless of whether participants believed they should give *hands-on* help or not, it was the carer's status as 'non-client' – precisely as Frida expressed – that was perceived as a challenge to fully help carers within the scope of their work. According to some of the participants, this was the main difference between them and professionals that provide direct carer support. While the Social Services Act obliged them to support carers, they also found this challenging because 'the client's needs are what set the direction' for care managers' work. Consequently, they felt that carers were *within, yet outside their scope*. Many felt that the carers' needs became 'hidden in the shadows' or 'forgotten' because of the mutual focus on the care receiver. Some also said that they lacked a structure or time to routinely investigate carers' needs for support:

Sometimes relatives cry on the phone and say, "I can't live with my situation anymore!" In these cases, I inform them that the municipality has direct carer support. But I wouldn't say that we have that routine [to investigate the need for carer support]. I guess I just do it when I sense the need for it. (Beth)

I wished we had more time. More time for the assessments. More time for home visits. So, we can sit down and talk one-on-one with the carer too. We must talk to the client, of course. But I wish we also had time reserved for talking to the wife or husband. Sometimes, we do [talk to the spouse], but [in situations] where it was necessary to do so anyway. (Dina)

One common dilemma experienced by the participants is when carers have an obvious need for respite, but a decision cannot be enacted because the client does not wish to receive formal care. In the Social Services Act, which has a strong focus on self-determination, the client must consent to the service even if its purpose is respite for the carer (Giertz et al., 2019; Nedlund & Taghizadeh Larsson, 2016). This situation became a dilemma for care managers, who felt hindered from providing the needed carer support.

We sometimes get applications from wives or husbands. We can receive their application, but we can never force the care receiver to receive respite care if they don't want it. We don't have any forced interventions. It's very tough to see a family carer, who has a husband or wife with dementia that needs so much care, when we see that the carer suffers and has poor mental health. It's very tough because we can't ... well, we can't force them. (Beth)

As not all clients have self-insight on their illness or the carer's situation, it often fell on the case manager to find a solution for both parties. In some cases, participants described trying to encourage the client to accept formal care for his or her own sake, but also with the carer's welfare in mind.

Another kind of dilemma arose when carers expressed the need for long-term planning. Participants believed that carers have a need for anticipating and planning *future care*. Carers want to make life more foreseeable and less chaotic, similar to what McSwiggan and colleagues describe as anticipatory care (McSwiggan et al., 2017). However, care managers can only make decisions based on the client's *present needs*. Although they understood the carers well, the care managers also needed to



abide by the rules. To reassure the carers, they tried in different ways to explain that help would be guaranteed the day the clients' needs would increase.

I sometimes get calls from carers who are worried about their relative's situation. They want to have answers. They want solutions. They want to be one step ahead and think ahead. But we have the Social Services Act to work with, and there there's no such thing as being one step ahead. It tells us to look at needs when they emerge. It goes against our basic need as human beings to want to plan. I tell them that they're on the right track to plan ahead, but we must ensure that we use resources wisely so that people who need help right now can get access to it. But I make sure that they feel that as soon as something *does* happen, we will be there to bring that help to them as soon as possible. (Hanna)

Finally, another dilemma care managers experienced was between the carer's expectations and local guidelines for service provision according to need. Many participants stated that their organisation prescribed a process of assessing for simpler services at home first, if clients were not in need of more expensive social care interventions such as residential care. These guidelines coincide with structural changes and resource effectivization in Swedish eldercare but has also meant an increased reliance on informal carers for performing minor tasks (Ulmanen & Szebehely, 2015). Many of our participants felt the weight of carers' expectations to receive a lot of help in acute situations, while the needs assessment process must take its course:

At the back of our minds, we must think about resources, our policies, and possible interventions to grant. Sometimes I know beforehand judging from the application that it will be denied. And yet the ball is on me all the time to fix the problem. But we can't always fix the problem. I think [carers] also expect the process to go very fast, because they ask for help when the situation is acute, they don't do it ahead of the fact. (Gun).

Care managers' dilemmas, as expressed by Gun above, also represent a paradox for carers. On the one hand, carers cannot be given anticipatory support because of the regulations of the Social Services Act, but when they do approach for help, they might first be offered simpler types of support than they expected. Consequently, our participants shared that part of their work was trying to instil a feeling of security in carers, for them to accept minor services and reassure them that their needs will be satisfied in time. Many felt that carers felt better when reassured that 'a little bit of help is very important too.'

The practice of assessing for present needs and granting simpler interventions before more expensive ones reflects an ambition for resource effectivity, but simultaneously reflects a reliance on *carers as resources* in providing help between the gaps of formal care. To a lesser extent, perhaps a view of a *superseded carer* is also present, where social workers – not the informal carer – are the ones thought responsible for worrying about the client's future care and defining what the care receiver needs (Law et al., 2021; Twigg & Atkin, 1994). Nevertheless, common to our participants' dilemmas is that the client's eligibility is what sets the conditions for the forms of carer support that are possible to provide. Consequently, carers are within, but somehow also over-and-above or even beyond the scope of care managers' role, as Isak describes:

It's good that carers come to us for help. Many times, I think we do more than is required. We help – often outside our job description – very much. But it's okay. They should be able to get help from us. It's our role to be there, to support, to be professional and to explain how everything works. On the other hand, I feel sorry to be this bureaucratic person sometimes when I have to talk about guidelines and stuff. It doesn't feel good to be in those shoes. But it's good that they come to us and can expect us to be professional and correct when it comes to the needs assessment. (Isak)

### **Possibilities and practices**

Because being a 'non-client' shapes the relationship between carer and care manager, it is also interesting to explore whether there are circumstances where carers do become *clients in their own right*. The UK is an example of where this is possible, as carers can ask for their own assessment, even if these are seldom carried out in practice (Courtin et al., 2014). In the Swedish Social Services Act,



there is also a possibility of *carer as client*, in a statute permitting social services in special circumstances. Previous studies have shown that this statute is used by care managers to allow spouse carers to live with their partners in needs-assessed residential care (Torgé, 2018). It is however unclear to what extent care managers use this statute to grant direct carer support.

In our interviews, the participants were aware of the statute, but few could give any examples where it was used for carer support. One participant mentioned the possibility of a small sum of financial compensation for spouse carers who voluntarily choose to provide care which would otherwise have been given by home help staff. Another participant working in disability services mentioned that direct carer support was more common in their area, since parents of children with disabilities can be entitled to their own support. However, most said that the statute was almost never used when it came to carers of adults. Accordingly, despite a legal possibility to directly help carers, this possibility was seldom enforced in practice as it is challenging to carry out:

[Carers] can apply for support on their own. But then there are so few possibilities to choose from. We don't have that much service for carers. It would be short-term service housing for the relative in that case, but then [the care receiver] still has to fulfill certain criteria for that to happen. (Johan)

If a carer applies for respite services to go outside of one's home, it's still a question of whether the care receiver wants to have another person there at home. Otherwise, it's not possible. So even if a carer really needs it, and they have a right to it, we can't enforce it. That's the difference between adults and family carers for minors. (Christina)

Some participants mentioned that their municipalities were aware of these challenges and have started exploring alternative ways for carers to be supported through this statute.

There are possibilities to promote carers' own interests too. An example of this from our interviews is when carers were hesitant to take in formal care at home (such as cleaning services) that both carer and care receiver could benefit from. In these cases, participants said they tried to show carers the value of indirect carer support for *the carer's own sake*. Such an example was given by a participant, who thought she had to be 'firm' with carers about accepting help:

There are times when I must accept that they will never accept formal help at home. But I also have to be firm sometimes and say, "I know that you have diseases and functional difficulties too, and it's not good for you to be under a lot of stress. Wouldn't it be good if your husband could get more help at home, for the sake of your own health?" (Gun)

Another form of support for carers was to be the 'spiders in the web'. They 'guided' carers to find support through other contacts, for the carers' needs to get acknowledged:

I can get questions [from carers] if there is anyone they can talk to. It's not processed as a case, but I do get them in contact with someone who can help them. It's not anything we assess for. We just try to lead the way. Maybe we don't have all the answers, but we know *where* they can get answers. Some of their questions are more clinical, and I can get them in contact with a nurse. Some are about practical everyday stuff like technical aids. I say, "call me if you have any questions" and I try to guide them. (Anki)

Statements like Anki's reveals the complex role of care managers in carer support. Because they are familiar with the care receiver's situation, they are in a unique position to ask carers directly about their mental health, investigate where support is lacking, and lead them to the right assistance.

I try to talk to carers and the care receiver and try to find out if they have other sources of support – if they have other people to talk to, get help from, if they have a safety net. If there isn't any and the carer has a difficult situation, I try to initiate a conversation like "Have you contacted health care services about your situation, are you getting any help from them?" If not, I can try to get them in contact with their primary health clinic, for their own health. If I notice that the family doesn't have a network, no one to talk to, and the carers are mostly alone, I really try as much as I can to get them to talk with the family care consultant for counselling and peer support. They can meet people there with similar experiences and talk about their own situation. We try hard to inform carers about these types of support, if we notice that they need extra support, feel unwell, and are grappling with difficult feelings. (Emilia)

Since the care manager's network also includes healthcare professionals, they are also able to get in touch with carers identified through the healthcare system, and thus investigate the need for services for the carer's relative:

We work closely with the primary health clinic. If a carer comes there and the health care staff see a need for it, they contact us so we can investigate and maybe start a process to get service for the care receiver. (Anki)

These examples show that there are possibilities to support carers, not only indirectly, but also directly, through the care manager role.

## Discussion

Due to the increased reliance on informal carers to both provide care and to collaborate with formal services, European welfare policies have underlined the importance of involving different professions in carer support (Zigante, 2018). While carer support provision is often thought to be the purview of professions such as family care consultants, counsellors and health care workers, this article shows that care managers are also deeply involved in communicating with, acknowledging the needs of, and providing different kinds of support for carers within their everyday work. Even though carers are not necessarily clients in the needs assessment process, insights from our interviews show the complex ways in which the situations and needs of care receivers and carers intertwine. Consequently, care managers also constantly deal with matters of carer support.

One consequence of our results is the problematization of the concept of 'client' in social work. The terms 'clients' or 'service users' refer to individuals who have a professional relationship with a social worker. These terms, however, exclude people that are in contact with social workers but are not eligible for services (Banks, 2020), such as informal carers. Understanding carers as 'co-clients' has typically been reserved for the most heavily stressed carers who require health interventions (Jegermalm & Torgé, 2023), while in general, social workers' responsibilities towards carers have been less clear (Dunér, 2018; Janlöv et al., 2011; Torgé, 2020). A possible reason for this is that even though carers are increasingly acknowledged as a group with rights to carer support, they are not formal applicants for social services. A discussion missing in the dilemma of carers as non-clients might well be a rights-based approach that would include carers in the purview of care managers *a priori*. The participants in our study seemed to fluidly view carers as co-workers, resources, carers to be superseded, and clients of social – and health care services (see Twigg, 1989). This view seems to reflect a general ambiguity in the role of carers as necessary resources in ageing and changing welfare systems, yet a vulnerable group that should be helped in their caring role.

The policy-driven task to adopt a carer perspective was apparent in the interviews. Contrary to many care managers' belief that carer support was not included in their work (Nilsson et al., 2022), our results show that care managers can and do provide different kinds of hands-on support for carers. They do this through listening and giving advice to carers in crisis, encouraging carers to apply for help, and (to a lesser extent) through direct support and guiding carers to other services. Participants also talked about supporting carers *despite* experienced barriers such as lack of routines and time, and legal frameworks less suited to carers' situations. These dilemmas emphasise the fact that implementing carer support, despite ambitions for individualisation, is only possible within what Lipsky (2010) described as broader policy structures governing the work of street-level bureaucrats. One of the clearest examples of this from our study is how direct support to carers was seldom possible, due to policy gaps. Similar situations are found in other countries where carer assessments are possible, but are seldom made (Glendinning et al., 2015; Seddon et al., 2010). Nevertheless, our participants' experiences of supporting carers in ways that sometimes felt 'beyond' their work could be interpreted as street-level bureaucrats' attempts to adjust to, or bridge the gap between, occupational demands and the demands of the situation, face-to-face with carers. In some cases, the experienced gap could lead some to adopt a *hands-off* attitude towards carers. However, when succeeding in bridging the gap, care managers can nevertheless

be – despite not having carers as clients – the human face that translates the carer perspective from abstract policy to practice.

The recently formed Swedish National Carer Strategy (Socialdepartamentet, 2022) mandates that both social work and healthcare integrate a caregiver perspective into all services. In light of this, The National Board of Health and Welfare in Sweden has disseminated guidelines for municipalities on how to develop and implement a caregiver perspective. While these guidelines may positively influence social work practice, further research is needed to expand upon them.

A limitation of this study is that the participants were limited to 10 individuals in two Swedish counties. We know that local frameworks and local circumstances impact the interpretation and implementation of national guidelines (Vingare et al., 2020). Sampling for a wider geographical spread could possibly have revealed other strategies and local policies. However, the municipalities where our participants worked did vary in size and population and represented a mix of large-, mid-sized and small municipalities. Another possible limitation is the self-selection of most of the interview participants. After reading the information letter, care managers could contact the research team directly with a wish to be part of the study. This approach may have resulted in interviewees who were already interested carer support. In Nilsson et al.' survey (2022), an explanation offered for care managers' seeming disinterest with carer support could be the lack of awareness that their actions constitute carer support. In contrast, our interview participants might be more cognizant of the carer perspective. As we reported in our study, however, not all participants had the same views on how engaged one should be in hands-on help for carers.

A strength of the article is that it has focused on a group whose role in carer support is hidden and taken for granted. To our knowledge, there are few scientific studies on carer support provision from care managers' perspectives, even though this group represents the front line of social service provision. This study has highlighted care managers' important role and multifaceted work with carers.

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