



Collaborative practices between correctional and mental health services in Norway: expanding the roles and responsibility competence domain

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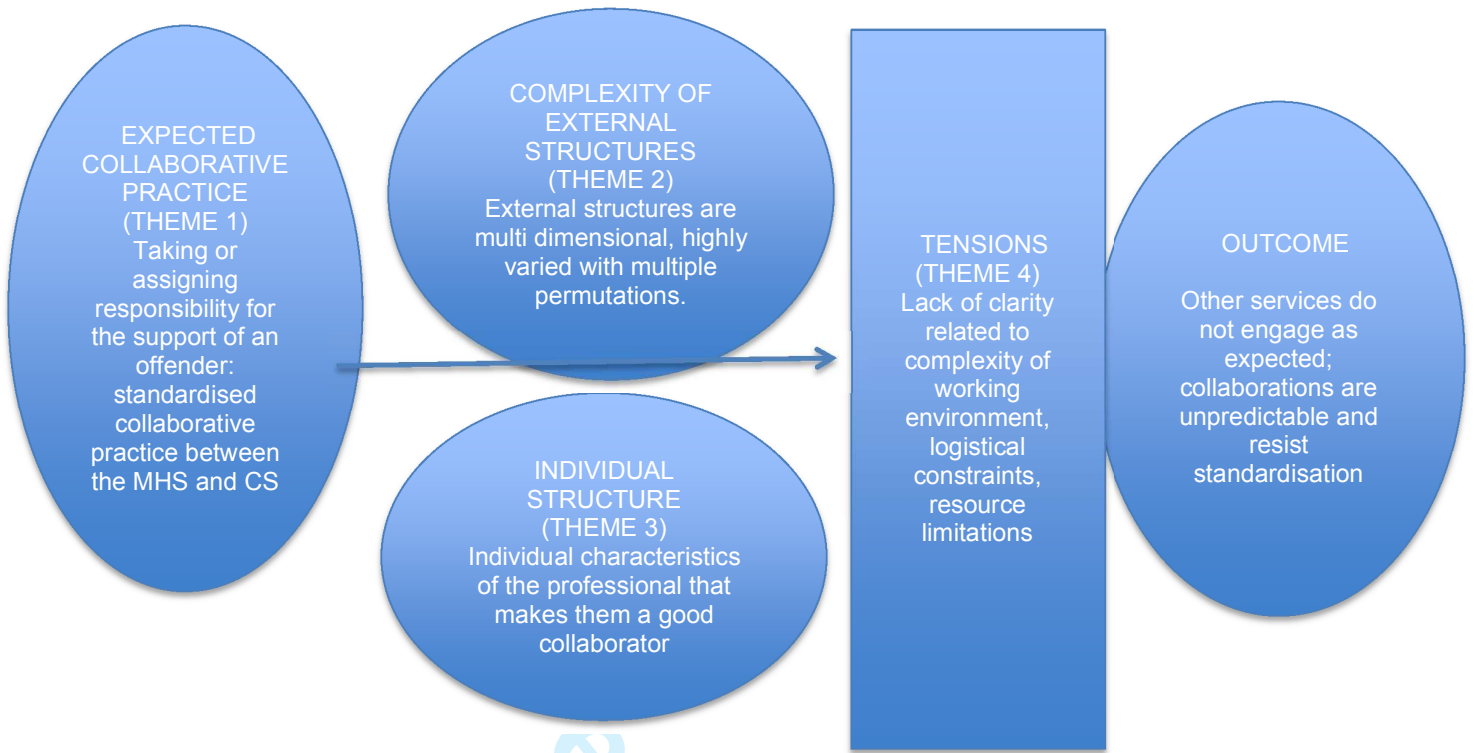


Figure 1: Interrelated themes describing responsibility distribution in collaborative practice between the MHS and CS.

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Abstract

Internationally, mental illness is high in prison populations. Collaboration between the correctional services (CS) and mental health services (MHS) is required to address this. Little is known of the collaborative processes in this context, however. This paper presents the findings of a study exploring the characteristics of collaborative practices between the MHS and CS in a Norwegian context. A purposeful sample (n=12) of MHS and CS leaders was recruited from one region in Norway. Taking a generic qualitative approach, semi-structured interviews with each participant explored specific structures that promoted collaboration, the nature of collaborative relationships and factors that facilitated or constrained these. The study indicated that leader are exercised by one dimension of collaborative practice in particular, namely the distribution of responsibility for the care of the offender across systems. This activity is mediated by highly complex external structures as well as the individual characteristics of the professionals involved. They speculate that professionals and organisations who fail to take responsibility for the offender as expected, may be constrained from doing so by resource limitations, logistical issues and poor attitudes towards the offender population. Based on these findings, this study suggests that the MHS and CS workforce would benefit from a great knowledgeability of the roles and responsibility domains of collaborative practice. Improving competence in the workforce in this area would achieve this. However, competency frameworks that address this domain are currently limited. Recommendations on how to extend the remit of this domain, in light of the current findings, are provided.

Introduction

Although Norway's reoffending rates are comparatively low, 20% of offenders will receive a new conviction within two years (Kristoffersen, 2013). Mental illness is one of the risk factors associated with this reoffending (Sapouna, 2015; Chang, Larsson, Lichtenstein, & Fazel, 2015; Armstrong, 2012; Skeem & Peterson, 2011), of concern as mental illness is high in prison populations internationally, including Norway, where 92% of offenders have some form of mental health issue (HelseSørØst, 2014). Mental illness does not occur in isolation, however, being closely intertwined with a range of childhood stressors and other

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3 welfare deficiencies (Friestad & Kjelsberg, 2009). Reducing reoffending hinges on mental
4 health being treated in tandem with other welfare needs.
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8 Correctional Services (CS) increasingly take a rehabilitation and reintegration approach as
9 a more holistic and humanitarian to tackling the challenge of reoffending. This is an
10 alternative to a punishment or deterrent related focus. Hereby the CS explore ways
11 through which offenders can be supported to address their current health and welfare
12 needs and sustain their desistance behaviours in the longer term (Armstrong, 2012).
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18 The focus on reintegration is put into practice in the Norwegian context through the
19 normality principle that stresses the importance of offenders receiving the same services
20 as those available to the wider population (Norwegian Ministry of Justice and the Police,
21 2008). Nurses and prison doctors, employed by the local municipality, and mental health
22 professionals employed by specialised mental health services (MHS) in regional hospitals,
23 work within the prison offering mental health and substance misuse services to offenders
24 on a part or full time basis. Further, a reintegration guarantee is in place (Sverdrup, 2013;
25 Armstrong 2012;) where offenders upon release, have the right to an offer of employment,
26 education, suitable housing accommodation, some type of income, medical services,
27 addiction treatment services and debt counselling. Prisons and multiple health and welfare
28 services work together to deliver this and co-ordination posts (tilbakeføringkoordinator-
29 TFK) have been introduced to coordinate this collaborative activity at a systems level
30 (Sverdrup, 2013). This reflects recommendations provided Europe-wide by the Justice
31 Cooperation Network, (2012) that highlighted collaborative working as key to reducing
32 reoffending. Despite these recommendations, little is known about what characterises
33 collaborative practice in this context.
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46 *Dimensions of Collaborative practice*

47 Collaborative practice between health and welfare services more generally is a
48 multidimensional and multilevel construct (Ødegård 2006, Willumsen, 2008). At a
49 structural level, collaborative practice is an external feature of service organisation: a
50 balance between ways in which units are differentiated from each other (e.g. the specialist
51 sections or departments the organisation is divided into and the type of personal employed
52 within them) versus the structures that integrate or establish continuity between these
53 units (e.g. interprofessional teams or team meetings). This differentiation and integration
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3 occurs both within and between organisations (Willumsen, 2008). Stones (2005) suggests
4 that these external structures impact on individual agency, in this instance a professional's
5 collaborative practice. The latter is mediated also by structures internal to the individual
6 professional. Perceptions of collaborative practice are one such internal structure and
7 may include the way a professional views the professional power differences between
8 collaborators (Ødegård 2006). Although the longer term impact of collaborative practice on
9 population health and the quality of care and patient experiences are difficult to establish
10 (Brandt, Lutfiyya, King, & Chioreso, 2014), improving collaborative practice, as a focus of
11 organisational quality improvement, has been linked to positive service user outcomes
12 including reduced length of patient hospital stay, lower costs, improvement in the way
13 drugs are prescribed and increased audit activity (Zwarenstein, Goldman, & Reeves,
14 2009). In the innovation literature, the space between different groups of collaborator,
15 demarcated by professional, departmental or organisational boundaries, is described as a
16 highly productive area where a diversity of ideas meet and generate socially innovative
17 solutions to practice problems (Vangen & Huxham, 2013). However, these can also be
18 challenging places to negotiate (Akkerman and Bakker, 2011; Edwards, 2011).
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31 Improving collaborative practice within this boundary space between the MHS and CS is
32 specifically important not only because of its potential in the longer term to improve
33 offender outcomes but also because of its shorter term potential to enable service leaders
34 and front line workers alike to generate joint solutions to the rapidly changing needs of the
35 offender population. Bond & Gittell, (2010), for example, find links between collaborative
36 practices between support agencies and reoffending rates. Other than these authors,
37 however, collaborative practices between the MHS and CS is under-investigated despite
38 an equal need for the CS and MHS to combine forces to develop ways of working that are
39 cost effective and deploy resources differently and effectively (Hean, Willumsen &
40 Ødegård, 2015). This paper therefore presents findings of a qualitative arm of a wider
41 study that explored the MHS and CS leaders' perspectives of the characteristics of
42 collaborative practices between their services in a Norwegian context
43 (http://cordis.europa.eu/project/rcn/188119_en.html). The paper reports a dominant issue
44 arising from interviews that related to professional responsibility and how this is negotiated
45 between professionals across the MHS and CS boundary.
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Method

The research described in this paper is the first and exploratory phase of a wider study that explored collaborative practices between the MHS and CS in a sequential mixed methods design (Tashakkori and Teddlie 2003).

Sample

To explore the characteristics of collaborative practices between mental health and correctional services in a Norwegian context, a purposeful sample (n=12) (Patton, 2002) of administrative leaders from both the MHS and CS were recruited from one of the five regions into which the Norwegian CS are divided up nationally. Participants were recruited on the basis of their key leadership status in the region and their ability to give a rich and heuristic overview of each system and the collaborations between them. Although representation from both the CS and the MHS was required, there was an element of snowballing associated with the sampling as interviewees were asked to identify other relevant leaders in the course of their interview (Patton, 2002).

The sample comprised of six female and six male leaders. Regional leaders in the correctional services, prison leaders and probation leaders (n=5) were represented, as were leaders in general prison health services (n=2), prison social services (n=1) and specialised mental health services (n=2). Individuals perceived to have overview of both the MHS and CS systems were also included (representatives from county offices and a senior researcher in the field (n=2). Professionally these leaders were trained as lawyers (n=3), social workers (n=4), nurses (n=2), a medical doctor, psychiatrist and family therapist.

Data collection

A critical realist stance was taken in the study with the perspective that whilst a reality of collaborative practice between systems existed, this reality is individually interpreted by each individual (Bhaskar, 2008; Stones, 2005). Empirically, the experiences of leaders in the MHS and CS of the external reality of collaboration and structures that mediate collaboration were explored qualitatively using semi-structured interviews as the method of data collection. The interview guide explored inductively how the MHS and CS work together in practice. Specific prompts related to the range of services involved, specific

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3 structures in place to promote collaboration, the nature of relationships between services
4 and what facilitated or constrained how they worked together.
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8 The interviewer kept a reflective diary (Patton 2002) on the conduct of the interview. The
9 interviews were at the workplace of Interviewees, 1-1½ hours in duration, except in one
10 instance where a respondent chose to extend the duration of the interview voluntarily. The
11 interviews were conducted in English by the first author but together with a Norwegian-
12 speaking colleague (second author) to clarify language issues arising. In two cases,
13 Interviewees requested a colleague to attend to assist with language issues.
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19 *Analysis*

20 Interviews were transcribed verbatim and analysed in parallel to data collection in order
21 that emerging themes could be more fully explored in future interviews. Interview tapes,
22 transcripts and quotations were anonymised. Analysis was conducted QSR NVivo 10 to
23 manage the data. An inductive thematic analysis of interviews was conducted following
24 methods recommended by Graneheim & Lundman, (2004). This involved familiarisation,
25 identification of meaning units (usually a sentences or groups of sentences that captures a
26 single concept or idea) and assigning each meaning unit a brief heading summarising its
27 meaning in an open coding process. These codes were grouped into higher level
28 categories, clearly rationalising membership of each category in a constant comparison of
29 the categories. Sub themes and themes, that represented the concept underpinning a
30 category or group of categories, were created through a process of abstraction. The initial
31 analysis, creation of categories and themes and overall description of each theme was
32 shared with a panel of qualitative Norwegian researchers to confirm the trustworthiness of
33 the categorisation and abstraction process (Shenton, 2004).
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46 *Ethical considerations*

47 Ethical clearance for this and all work packages of the project was obtained from the
48 Privacy Ombudsman for research, the Norwegian social science data service (NSD) (Ref
49 nr: 39534) and separately from the Director of the Criminal Justice region being
50 investigated (Vår ref: 201313560-5).
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56 **Findings**

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3 A wide range of themes emerged from the analysis. In this paper we have chosen to
4 describe four themes that were interrelated and specifically related to collaborative
5 practice and taking responsibility for the care of the offender (see Figure 1). The first
6 theme described MHS and CS leaders' views of what they expected collaborative practice
7 to look like and for responsibility for the care of offender to be distributed between
8 professional groups (theme 1). They then explain how these standard or expected forms
9 of collaborating are mediated by the complexity of these interagency working
10 environments (theme 2), the individual characteristics/structures of the professional
11 engaged in the collaborative practice (theme 3) and a range of tensions challenging these
12 collaborative spaces (theme 4).
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21 *Expected collaborative practice (theme 1):*

22 Interviewees describe standard patterns of collaboration: the expected responsibility
23 distribution within and between systems. They discussed how collaborations between the
24 prison and specialist mental health services are expected to function and in the Norwegian
25 prison environment, how the mental health of the offender should be addressed, in the first
26 instance, by the prison nurse who refers on to the prison doctor where necessary. If these
27 professionals believe the mental illness surpasses a particular severity threshold,
28 offenders are referred to specialised mental health professionals from secondary care
29 organisations that visit the prison on a regular basis or alternatively to health professionals
30 outside of the prison with whom the offender may have had contact prior to arrest. If the
31 condition is acute, and specialist professionals are not available on site, the offender is
32 transported out of the prison to specialised mental health services for treatment.
33 Expectations of responsibility taking and reality can differ as illustrated when the MHS and
34 CS negotiate how responsibility for the patient is transferred between prison and specialist
35 mental health staff:
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48 I think if you ask the GP in the prison, he will say that the specialised health
49 services has the threshold to take someone into the specialized service too
50 high...and if they (*the offender*) come to the specialised service then this might
51 be for a short while, some hours, and then the prisoner is going back to the
52 prison and the prison finds that the treatment they can give is not good enough
53 (Regional Health Lead).
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3 Deciding which of these professionals, inside or outside of the prison, should take
4 responsibility for the offender is especially important at the beginning of sentence when
5 needs and risk assessments are carried out with the offender and plans made for
6 rehabilitation activity over the duration of their sentence. It is also important when
7 preparing offenders for release and external professionals are engaged in the
8 reintegration process well before the sentence end. Interviewees felt it was important for
9 collaboration between MHS and CS that these divisions of professional responsibilities
10 between and within systems are made clear at these points, although they felt this not
11 always to be the case.
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20 It has something to do with responsibility. No one is responsible. There are so
21 many people and the responsibility is divided. Someone has responsibility for
22 the mental health, someone for housing and they don't speak together (Prison
23 Nurse Lead).
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28 Interviewees assign responsibility primarily by virtue of perceived professional or
29 organisational function and expertise to help the offender. For example, responsibility for
30 diagnosing and providing advice to the prison on the management of acute mental health
31 conditions is assigned to specialised services although nurses talk of their own
32 professional skills and role in providing mental health support.
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38 We are not the experts. They are the experts (referring to specialised
39 mental health services). We need their help. They are experts in their
40 areas (Prison CS Lead).
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45 Within the CS, they describe how different functions are distributed unprofessionally (e.g.
46 how responsibility for different wings of the prison are distributed between nursing staff)
47 and interprofessionally (e.g. prison nurses are responsible for offenders' health needs and
48 prison social workers for housing or employment needs or different professionals having
49 responsibility for initiating interventions whilst others follow).
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54 So we usually don't initiate. So if they don't have an individualised plan, we
55 usually don't initiate unless we see this is just a mess and we have to do
56 something: if there is something wrong on the outside. If there is a lot of health
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3 issues meaning drugs, mental health issues and its just a chaos, and we see
4 that the patient will stay here for a while, we have to work on it. It is usually the
5 social worker who initiates. If someone initiates something, we are then asked
6 if we want to participate in the meeting. (Prison Nurse Lead).
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11 There are examples given of professions sharing responsibility (e.g. the offender's needs
12 assessment being shared between prison officers and prison social workers).

13 Responsibility is also distributed at an interorganisational level (e.g., in programmes for
14 sex offenders, probation officers recruit to the programme, and the specialised mental
15 health services deliver the programme content).
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21 I think it's that we share responsibility. We don't sit with the responsibility all
22 alone in the prison. We have someone outside to collaborate with and its much
23 easier and we feel that people outside are interested in our inmates (Prison
24 Social Work Lead)
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30 Interviewees described the responsibilities of regional leaders (e.g. disseminating good
31 practice) and the municipality (e.g. initiating an individualised plan- an interagency
32 coordination tool- for the offender). Responsibility is also distributed geographically (e.g.
33 responsibility for mentally ill offenders is distributed between district and regional specialist
34 services dependent on the home municipality of the offender).
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40 I think it is a good thing that the Kommune (*municipality*) take over. They can
41 be in a kommune far far way and it is not logical that we sitting here should
42 have anything to do with the person outside but I think it could be better if were
43 better at involving the kommune or if the kommune could be better at getting
44 involved (Prison Nurse Lead).
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50 Other responsibilities relate to the need to make referrals at appropriate times, prison
51 officers for example, have responsibility to contact MHS services within a stated time
52 period if an acute mental health issue is suspected. Interviewees also talk of responsibility
53 more generally stating for example, how the municipality needs to take responsibility for
54 the offender before release and the need for prison officers to get involved in the welfare
55 of the offender.
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Responsibilities, that are not treatment related, are described as well: the prison doctor and TFK coordinator role, for example, are described as bridge builders, coordinating relationships between mental health/ other welfare services and prison services at individual and systems levels respectively.

The complexity of external structures (theme 2)

Working together between the MHS and CS is not a straightforward matter but a complex one in which professionals need to negotiate a plethora of many interconnected dimensions. Interviewees describe having to cross multiple boundaries and encountering much contextual variation. This poses challenges related to determining where professional limits lie, finding the right person within the other organisation to take responsibility for the offender and they express frustration when other professionals sometimes fail to take up the responsibility they expect of them. For example, when describing trying to get the municipality involved in the care of a serial and mentally ill offender:

They had all sorts of excuses. They didnt have time. It was inconvenient. All kinds of excuses. So we were disappointed with the community (Prison Social Work Lead).

Interviewees explain how professionals from both health and welfare services, as well as correctional services, negotiate geographical, interorganisational and intraorganisational boundaries when looking for professionals with expertise/capacity to take responsibility for the needs of the offender. They describe how professionals travel across Norway to engage with professionals from different counties, regions and municipalities. They do so to seek out expertise needed to support the offender currently serving sentences or when trying to reintegrate the offender back to their home area when they near release. They seek out the expertise of professionals within their own system or across systems, engaging with a range of public sector (e.g. welfare service, prisons, regional hospital, municipality health services, police) and not-for profit organisations (e.g. Salvation Army). Each of these organisations has additional complexities within their structures caused by divisions into different departments or units, programmes or services, a plethora of official roles and titles and other employment complexities (such as professionals working part

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3 time between two or more organisations or being paid for by one organisation but located
4 in another). The employment of health staff based in the prisons on a full or part time
5 basis, by the municipality, through the import model of service provision (Norwegian
6 Ministry of Justice and the Police, 2008), is an example of this as is the multi-layered and
7 variable structures within the social security systems (NAV) outside of the prison, an
8 organisation with whom prisons need to collaborate closely when preparing prisoners for
9 release.
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16 The problem in x municipality is that NAV (social security) is very divided, or
17 sectioned...specialist. They often have one saksbehandler (case manager) in
18 economy and one saksbehandler in housing and one in RUS (Drug treatment).
19 So its a lot of people..... So its very difficult for us to find out who is doing
20 what? But in the small community, NAV does everything. One person in NAV
21 can work with economy, with housing, with drugs, so that's much
22 easier...(Prison social work Lead)
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30 Collaborations occur vertically between individuals working at different levels of
31 organisational management (e.g. prison leaders seek advice from regional CS leaders or
32 CS leaders engage with Ministerial bodies) or horizontally across professional boundaries
33 (e.g., psychologists and psychiatrists from specialised mental health services interact with
34 prison officers and lawyers in the CS system).
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40 Finding the right professional to take on responsibility for an offender may also vary
41 depending on the demographical characteristics of the offender (e.g. young offenders,
42 foreign offenders), the location in which their sentence is executed (probation or prison)
43 and/or the offence committed (e.g. sex offenders).
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49 At a national level, Interviewees describe how the health and correctional services divide
50 responsibilities into alternative geographical regions, each with different budgets and laws
51 and managed in different ways. At the municipality level, the distribution of roles,
52 responsibility and key organisational contact points differed from municipality to
53 municipality, reflecting the autonomy of municipalities in Norway, and some municipalities
54 have sizeable offender populations under their jurisdiction whereas others do not. There
55 is further variation at an organisational level between each prison. Prisons are managed
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3 differently in terms of the number and type of staff employed, the distribution of
4 responsibility between professions as well as in the degree and nature with which state
5 driven interventions are implemented. Interviewees illustrate this variation by referring to
6 the variation with which the TFK coordination role has been introduced nationally, for
7 example.
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13 Added to these structural differences, interviewees describe variations in professionals'
14 knowledge of other organisations and that different groups may hold different values and
15 philosophies towards the offender (e.g. along a rehabilitation versus punishment
16 spectrum). Further, every category of offender (classified by offence for example) and
17 every individual offender has a different permutation of needs.
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23 The variations at national, municipality, personal and organisational levels leads
24 Interviewees to describe their task of seeking out the expertise of other organisations as
25 extremely complex and uncertain. The above complexity creates much variation in the
26 way responsibility is distributed geographically and administratively. This limits the
27 predictability and standardization of collaborative practices between health, welfare and
28 CS systems.
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34 I needed them as interview subjects to tell me what happens, what they think of
35 the relationship between the different organisations and the different
36 organisational levels. Prison regions are organized differently from the health
37 regions, from the court regions, so all these regional, municipal and state
38 structures makes it enormously complicated. They have different ways of
39 organizing decision making, budgets and services and knowledge all over the
40 country. I would really want them to tell me as this would really help them and it
41 would help me in my evaluation task (Research leader).
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49 *Individual structures (theme 3)*

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51 Interviewees generally found it difficult to pinpoint what made a good collaborative worker
52 in this field but if prompted they talked of the characteristics of the individual professional
53 impacting on the quality of the collaboration and whether other professionals took active
54 responsibility for an offender's care. They describe the importance of commitment,
55 personal resolve and passion to bring about change for the offender, as factors that drove
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3 this. They see positive attitudes towards the offender as a key driver to collaborate, being
4 less likely if the other professional was afraid of, or prejudiced against, working with
5 offenders or a particular group of offenders (e.g. sex offenders). Leaders in the sample
6 believe however that this is changing and that attitudes in the municipality, for example, to
7 offenders have improved over time, that professionals in health and welfare services are
8 more open to working with this group than they have been and that this is due to better
9 preparation in their training.
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16 They have attitudes. Twenty eight years ago, older NAV people were sitting in
17 an office...they were very afraid of prisoners. Now it's more open and the
18 people who work there know a lot about RUS (*drugs*), about social problems
19 and they can see it as a whole. There is a better understanding that problems
20 when you are young can cause bigger problems when you are older and you
21 have to...to see these things. You can't see a little bit of the person (Prison
22 social work lead).
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30 Interviewees describe the need for professionals to be outwardly facing. This meant the
31 professional should be prepared to reach out actively to engage both with the offender and
32 other professionals or organisations, rather than waiting for the offender or other
33 professional to come to them. It also means that professionals should be open minded to
34 alternative views expressed by other professionals and have the flexibility to take on board
35 alternative ways of doing things that these other professionals may bring to the
36 collaboration.
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43 We focus on understanding each other's role and what they do in their everyday work
44 so that we can understand each other. It's in those morning meetings for example,
45 which is really good. I don't know if other prisons do it but the nurses are participating
46 (Prison nurse leader).
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51 Interviewees believe that professionals should be able to see the offender as a whole,
52 linking the many threads of their complex needs. They need to appreciate that
53 developing professional and offender networks takes persistence, optimism and patience
54 and will proceed slowly and incrementally. They need to be assertive in their collaborative
55 dealings standing up for what they believe but exhibiting strong social and relational skills
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3 when doing so and being strategic in their thinking. They need also to keep up to date in
4 their field but simultaneously know the limits of their professional remit. Much of these
5 skills and knowledge of what works, and what does not, is recognised as coming with a
6 professional's years of experience.
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11 They have to be able to see the whole. They have to be good in their field but
12 at the same time see the whole. They have to...they cant just sit in their office
13 and hope prisoners will knock on their door. They have to go out and find them.
14 Work together with the people working out of the prison....and find out as much
15 as possible about this inmate. What are his resources and how can he be
16 helped best? (Prison Social work Lead)
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23 Finally, leaders speak of the importance of the professional having a close and personal
24 knowledge of the offender and their history. This is related also to the importance
25 professionals place on the offender being cared for by professionals that know them best,
26 and that transfer to specialist mental health services is not always the answer. They
27 discuss linking offenders to services to whom offenders are already known-their existing
28 professional network as well as their reluctance to refer to specialised mental health
29 services if prison staff can manage the offenders condition adequately themselves.
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36 We try and make an assessment about what they have on the outside if
37 they have a psychiatric doctor on the outside or if we can try an bring their own
38 doctor in, if that is possible.....Usually we have good time to get to know the
39 inmate and get information form the officers about how they interact with the
40 other inmates, how they interact at work, sleep, food. These kind of things.
41 Then we talk to them and try to make to see the whole picture We are trying
42 not to hospitalize. We are four nurses here. We are skilled nurses and we have
43 doctor here four times a week, a psychiatrist. We try and use that....to make
44 the best of it in here so that we don't have to...(Prison nurse lead).
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52 53 *Tensions when collaborating across systems (theme 4)*

54 A final theme relates to the tensions when collaborating across systems. A tension
55 identified and relevant to the allocation and acceptance of responsibility across the MHS
56 and CS, related to the challenges of negotiating how responsibility is distributed.
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3 Interviewees believed that there were several reasons that prevented other organisations
4 or professionals from taking on or fulfilling particular responsibilities related to the offender.
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8 Firstly, the division of responsibility across the multiple levels described is not always
9 clear. Interviewees attribute this partially to the fact that the allocation of responsibility
10 varies between regions, organisations and between municipality (see *complexity* theme).
11 They perceive this as having two main implications: first this lack of clarity leads to
12 confusion between groups as who should perform a function in any given situation (e.g.
13 should the police or specialised mental health services be responsible for controlling the
14 aggressive behaviours of a mentally ill person in the community; does the offender pass
15 the threshold of mental illness to be referred to specialist mental health services or can the
16 prison doctor, nurse or prison officer manage the condition as effectively?). Second, it
17 also means that professionals, when seeking to create or maintain the offender's support
18 network (both professional and social), find it difficult to identify a named contact within
19 any said organisation to take on the desired support function.
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30 No, it varies from municipality to municipality. So we have to just go that
31 certain to municipality and ask for the drug rehabilitation specialist.. or maybe
32 the GP can help....you were asking who we contact? And the answer is we
33 don't know. We just have to find out because there is no system? (Prison
34 Nurse Lead)
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40 The problem in (x municipality) is that the welfare service is very divided, or
41 sectioned, specialist. They often have one case manager in economy and one
42 case manager in housing and one in drugs rehabilitation. So its a lot of people.
43 So its very difficult for us to find out who is doing what? But in the small
44 community, the welfare service (NAV) does everything. One person in NAV can
45 work with economy, with housing, with drugs, so that's much easier...(Prison
46 Social Work Lead)
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53 Interviewees discuss examples of organisations denying responsibility (e.g. mental health
54 services believing the offender to be a drug addiction service problem and vice versa) or in
55 fact denying their own responsibility (e.g. it is not our responsibility to initiate an
56 individualised plan). Similarly they describe organisations as not performing a function the
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3 Interviewees believed should be assigned to them (e.g. expecting but never seeing an
4 individualised plan for an offender). There is much discussion about a need to get other
5 organisations or a professional group to take responsibility for the offender although the
6 power to enforce this across professional and organisational boundaries is lacking.
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11 We find it is very separated (drug rehabilitation and mental health). We were
12 hoping that the coordination reform would unify them. But we are not seeing
13 that in every day life as much as we were hoping. So often, sometimes we feel
14 that if we... if a doctor.... writes a letter to a rehab policlinic , then they say:
15 "We cant take it, there is too much psychiatric here". On the other hand, the
16 other side says; "There is too much drug issue here" (Prison Nurse Lead).
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23 Secondly, Interviewees believe logistical factors constrain opportunities for collaboration
24 between organisations: incompatible working schedules of professions in each
25 organisation and the geographical distances between the prison on the one hand and
26 community and specialised services on the other, means that building the network of
27 collaborators around the offender is challenging. It is especially so when, for reasons of
28 security, the services are encouraged to come to the prison rather than the offender being
29 transported, at expense, out of the prison.
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36 Across the board, limited human resources limit the capacity of organisations to engage in
37 the collaborative tasks of mapping and addressing offenders' needs. So in prisons only
38 the most needy receive a full needs assessment because of the limited number of staff
39 available to perform this role. Similarly limited capacity in the police force may restrict the
40 number of offenders in custody that can be transported from prison to specialized mental
41 health services in the regional hospital or the municipality may not be able to release staff
42 to come to the prison to address the needs of a particular individual. Other resource
43 issues include limited housing places in the municipality, limited beds in community
44 services, the need to make savings in current times of austerity, no service at all in the
45 home area of the offender and the fact that offenders needs are complex and addressing
46 these is cost intensive. These lack of resources means that opportunities for collaboration
47 are lost.
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3 Overall leaders describe professionals as having to rely heavily on their own professional
4 judgements to understand their own roles and responsibilities and that of other
5 professionals working within the same or other organisations.
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8 9 **Discussion**

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11 Stones (2005), building on Giddens' (1984), concept of structuration, seeks to explain the
12 relationship between structure and agency: the interplay between the real world and social
13 structures external to us and the impact this has on our individual ability to act. The agent
14 is the individual or individuals engaging in a particular activity or task. In this paper the
15 agent in focus is the professional from the correctional or health service and the activity
16 explored is the collaboration between professionals from the same or other system.
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18 Collaboration, as an activity in general, was a concept our interviewees found difficult to
19 articulate and they focused instead on one key dimension of this, namely the action of a
20 professional or organisation assigning or accepting responsibility for the care of the
21 mentally ill offender. They describe this activity in terms of how they perceive
22 responsibility for the offender to move, or be shared, between the MHS and CS (see
23 theme 1 Figure 1).
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33 In describing this activity, they indicate that this dimension of collaborative practice is more
34 complex than suggested by the following definition of collaborative practice, "when
35 multiple health workers from different professional backgrounds provide comprehensive
36 services by working with patients, their families, carers and communities to deliver the
37 highest quality of care across settings" (World Health Organisation, 2010, p13). The
38 collaboration in the MHS/CS context is more than between health professionals; it involves
39 prison officers, prison social workers, the police as well as psychologists, psychiatrists and
40 many others. Expertise is distributed across a range of organisations, levels and
41 professions. The type of collaboration described is less in keeping with traditional views
42 of stable team working but more in line with the concept of co-configuration in which the
43 expertise to help the offender rehabilitate is distributed across a range of loosely
44 connected professionals from a range of organisations who are required to collaborate
45 over an extended periods of time to support the needs of the offender as they progress
46 through the correctional services (Daniels, Leadbetter, Warmington, Edwards, et al.,
47 2007). This distributed expertise is typical in many health and welfare environments:
48 Edwards (2011) for example describes similar phenomenon and challenges in education,
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3 where school welfare managers access the expertise of multiple external organisations to
4 address the needs of children in danger of social exclusion.
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8 Structuration theory predicts that the collaborative activity described by MHS and CS
9 leaders will be constrained or facilitated by external structures. The complexity theme
10 (Theme 2 Figure 1) describes some of these external structures that mediate the collective
11 action (Stuart, 2014) of assigning and accepting responsibility for the care of the offender
12 (e.g. the organisation of services regionally and nationally). Leaders describe these
13 structures as multi-dimensional, highly varied and to combine in multiple permutations.
14 This complexity of these external structures means MHS and CS professionals must cross
15 multiple boundaries created by geographical distribution of services as well as intra and
16 interorganisational borders. The Interviewees' demarcation of boundaries between units is
17 a generic feature of the collaboration process, being described in other contexts as a first
18 step in boundary crossing (Akkerman & Bakker, 2011). This is described by Engeström,
19 Engeström, & Kärkkäinen, (1995) as a form of polycontextuality, in which professionals
20 cross boundaries of demarcated expertise to engage with multiple communities of
21 practice.
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33 Collaboration between the criminal justice and mental health systems is influenced by
34 structures external to the agent but is influenced by structures internal to them also (See
35 Figure 1, theme 3). Internal structures have two components: Bourdieu's (1986) concept
36 of *habitus* of the agent and *knowledgeability* that the agent has of external structures
37 surrounding them. *Habitus* describes the predispositions, history, social and human
38 capital distinct to each individual and that constrains or facilitates their actions (Stones
39 2005). In this study, the internal structures, impacting on the way professionals take or
40 assign professional responsibility, is described in theme 3 (See Figure1) and the
41 characteristics of the individual professional suited for collaboration (e.g. being outwardly
42 facing). These features mediate the likelihood that professionals will effectively cross inter
43 and intra organisational boundaries, described in theme 2, required to negotiate who
44 should take responsibility for the offender, when and how they should do this.
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55 Finally, although initially constrained by external and internal structures, collaborative
56 practice between the MHS and CS, is further constrained by key tensions within the
57 interactions (that include lack of clarity on responsibility, logistical and resource limitations
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3 (see Figure 1 theme 4). The complexity of working environments contributes to the lack of
4 clarity on responsibility taking described.
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8 All four of the themes may interact to dictate how individual professionals and
9 organisations effectively engage and take responsibility for the support of an offender and
10 how this responsibility taking is negotiated between professionals across the MHS and CS
11 boundary (see Figure 1). In other words, the way that responsibility is distributed between
12 organisations and professionals is a product of the complexity of the external structures
13 surrounding this practice, and typical of any complex open system (Kernick, 2003). It is
14 feature also of the internal structures of individual professionals engaging in this collective
15 activity as well as a range of tensions within the system. Combined these create an
16 environment in which stakeholders, engaged in collaborative activity between the MHS
17 and CS, may not take on responsibility for the offender as expected (Figure 1) which is
18 reflected by interviewees when they describe the unpredictable and changeable practice
19 context, where they must rely heavily on their own professional judgements to understand
20 their own roles and responsibilities and that of other professionals working within the same
21 or other organisations. This is recognised as a key characteristic of interprofessional and
22 interagency collaboration in other contexts also (Ødegård, 2006; Atkinson, Doherty, &
23 Kinder, 2002). In some health care contexts there will be routinized procedures (Akkerman
24 and Bakker, 2011) or standardised care pathways that will make this decision making clear
25 cut: that lays out who is responsible for what task and when. However, in this MHS/CS
26 context, and in Norwegian health and welfare contexts in general, these structures are
27 often vague, lacking routinized procedures about whom to involve and when (Willumsen &
28 Skivenes, 2005). In fact, the individual and changing needs of offenders represents a
29 particular challenging or 'wicked problem' that resists standardisation or the formulation of
30 standardised treatment pathways (Rittel & Webber, 1973).
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51 **The way ahead**

52 There will be various approaches to improve collaborative activity in the MHS and CS
53 context in the future. A focus on improving external structures is one, but the challenges
54 that face standardisation of these in this complex environment, means that a focus on
55 internal structures instead may have more traction. Stones (2005), in his description of
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3 internal structure influences, describes a *knowledgeability* dimension which he defines as
4 the awareness by the agent of the external structures that surround them and their ability
5 to work within these. The more awareness they have of the external structures around
6 them, it is hypothesized that the more likely it is that there will be fewer unintended
7 consequences of the agents action. This is a key competence required to work
8 collaboratively and a competence related to making decisions about assigning and taking
9 responsibility.
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16 The importance of the dimension is partially reflected in the specific *role and responsibility*
17 domain within some collaborative competency frameworks. The Canadian National
18 Collaborative competencies framework, for example (Orchard & Bainbridge, 2010)
19 describes a range of competence domains (interprofessional communication,
20 patient/client/family /community-centred care, role clarification, team functioning,
21 interprofessional conflict resolution and collaborative leadership). Focusing on the role
22 clarification domain, this competence is an ability to articulate one's own role and the roles
23 of other professions, understand how these complement one another, and use this
24 knowledge to treat the patient holistically. Similarly, the Interprofessional Education
25 Collaborative (2011) competency framework describes a *role and responsibilities* domain
26 as the ability to, "use the knowledge of one's own role and those of other professions to
27 appropriately assess and address the healthcare needs of the patients and populations
28 served" (p.21). It reiterates the need to communicate one's own professional
29 responsibilities to others, to understand those of other professions, knowing where
30 professional limitations lie and being able to develop and manage the interdependent
31 relationships between the diverse professionals and skills available.
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44 What is described in the roles and responsibility competence domains above
45 (Interprofessional Education Collaborative, 2011; Orchard & Bainbridge, 2010) is what
46 Miller, (2001) describes as the principle of professional capacity. In other words,
47 professionals, when looking to assign responsibility for a dimension of offender care,
48 decide which professional is best qualified in terms of professional skill to help the
49 vulnerable individual. Our Interviewees take this approach when describing which
50 professionals and organisations have responsibility for what offender need in theme 1.
51 For example, the psychiatrist is best placed to treat mental illness. However, there are
52 other principles at play as Miller (2001) suggests that, although a professional may have
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3 the capacity in terms of training, to take on a particular responsibility, the cost to the
4 individual professional to perform this task may be too great. A prison social worker may
5 believe, for example, that a municipal worker has the capacity (in term of training and role)
6 to address an offender's future sheltered housing needs, but personal, logistical and
7 resource costs to that professional and their organisation may make meeting these
8 obligations impossible. Weighing cost versus capacity is an important skill for the
9 professional in order to understanding role and responsibility dimensions of collaboration.
10 They need to demonstrate what Edwards, (2011) describes as relational agency and
11 Akkerman & Bakker (2011) as perception making: the action of understanding the practice
12 of another group, the ability to understand the constraints and priorities placed on another
13 agent and their ability to adapt their own behaviour accordingly. Leaders, when discussing
14 key tensions in the system (theme 3 Figure 1) that they believe leads to other
15 professionals not engaging in collaboration, demonstrates an element of this ability.
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26 In addition to capacity and cost, Miller (2001) describes a third communitarian principle
27 applicable to negotiating interagency collaboration. This relates to the strength of the
28 social ties held by the person in need. It is the responsibility of those actors with the
29 closest relationship to the person to take action rather than those unknown to them. In our
30 study this relates to the social ties of the offender discussed by Interviewees in the internal
31 structures theme 3 and of the individual characteristics of the individual professional
32 impacting on the quality of the collaboration. A prison nurse or prison officer, for example,
33 may have less capacity (in terms of experience or training) to treat the mental health of the
34 offender if compared to the psychiatrist in specialised mental health services but they have
35 responsibility because they are better known to the offender. Depending on the mental
36 health condition, this communitarian link with the prison officer may outweigh the higher
37 skill capacity of the specialised services, when decisions are made about who takes
38 responsibility for supporting the offender. This is in keeping with Appelbaum, Hickey, &
39 Packer (2001) and Dvoskin & Spiers (2004) who explore the multiple ways in which prison
40 officers can serve both as therapeutic agents in crisis intervention, prevention and the
41 delivery of on going psychotherapy, sometimes in ways that are more effective than that
42 provided by mental health specialists. It is also in line with the principle of lowest effective
43 level of care that predominates in the Norwegian health and social care system (Nylenna
44 & Larsen, 2005). In this context, the prison officers may in certain circumstances be both
45 the lowest level of mental health care and also the people that know the offender best.
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5 Miller (2001) argues that in assigning or distributing responsibility described, the principles
6 (we discuss capacity, cost and communitarian principles in this article) cannot be
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8 considered independently, but should be viewed pluralistically, weighing one way up
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10 against the other, before responsibility is assigned. We believe that all these principles
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12 should also be included in the roles and responsibility domain of collaborative competency
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14 frameworks, rather than the capacity dimensions alone, as is currently the case. A
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16 balance is required. Every collaborative situation will be different, complex and
17
18 unpredictable and the responsibility of educators is to provide students with the skills that
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20 enable them to make these judgements and to understand the range of factors that
21
22 influence who is best placed to support an offender. Collaborative competence
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24 frameworks need to be expanded beyond simply understanding responsibility in terms of
25
26 the functions that other professions perform in relation to one's own. Students need also
27
28 to explore the costs of the most skilled professional, such as the psychiatrist, taking on
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30 responsibility and providing treatment, and recognise those circumstances in which those
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32 who know the offender (such as the prison nurse or prison officer) may be better placed to
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34 take responsibility. They need also to consider the organisational resources and individual
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36 characteristics of the other professional when assigning responsibility for care to them.

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38 The study has its limitations that should be taken into account when considering its
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40 findings. Although the interviews provided in depth data, the size of the sample is a small
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42 one, confined to one region of Norway that will raise concerns of the transferability of
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44 these findings. Following analysis it became evident that, whilst municipality staff had
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46 been represented in the sample (the prison nurse), the voice of municipal workers based
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48 outside of the prison were missing and in retrospect important for better understanding this
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50 complex field. Further, although the level of spoken English was very high, the
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52 interviewees may still not to have been able to articulate their opinions to the same degree
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54 as if the interviews had been done in their native language. Although native Norwegians
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56 were involved in both the interviews and validation of the analysis, language and outsider
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58 status of the first author and main interviewer will have affected the nature of the data
59
60 collected. Lack of cultural familiarity will have offered the first author both novel insights
into collaborative practice in the region, but may also have lead to a misinterpretation or
failure to pick up relevant cues during the interview and analysis process. Finally the
concept of collaboration is an intangible one that Interviewees often struggle to articulate.

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3 Interview schedules should focus in the future on more specific activities (that required
4 collaboration) rather than about collaboration directly, to achieve greater understanding of
5 how collaborative practices in this context function (Engeström 2001)
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9 10 **Concluding comments**

11 In this study, we explored collaborative practice between mental health and correctional
12 services in a Norwegian context. We find that leaders are exercised by one dimension of
13 collaborative practice in particular, namely the distribution of responsibility for the care of
14 the offender across systems. This activity is mediated by highly complex external
15 structures as well as the individual characteristics of the professionals involved.
16 Professionals and organisations who fail to take responsibility for the offender as
17 expected, may be constrained from doing so by resource limitations, logistical issues and
18 poor attitudes towards the offender population.
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26 Based on these findings, the paper suggests that the MHS and CS workforce would
27 benefit from a great knowledgeability of the roles and responsibility domains of
28 collaborative practice. However, competency frameworks are currently limited, focusing
29 on a capacity dimension of responsibility assignment that articulates and interrogates
30 one's own responsibility and that of others as a trained professional. Whilst this is
31 important, it is more complex than this. Students should be encouraged also to consider
32 the cost for other professionals taking up particular responsibility. They should be given
33 the opportunity to weigh up Miller's principles of assigning responsibility, one against the
34 other, exploring the tensions and limitations of the other professional, as well the position
35 of the professional relative to the offender, when negotiating with other professionals and
36 organisations as to who has responsibility to alleviate the suffering of this target population
37 group.
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49 We acknowledge the extensive contribution of professionals in the Norwegian correctional
50 and specialised mental health services to this study.
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54 55 **Declaration of interest**

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3 The authors report no conflicts of interest. The authors alone are responsible for the
4 content and writing of this article.
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