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Mirrors of Prison Life—From Compartmentalised Practice Towards Boundary Crossing Expertise

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Introduction

The prevailing high rate of recidivism among ex-offenders, many with mental health problems, is indicative of the fragile nature of resocialisation processes and the challenges faced in the interactions between the two distinct institutions of "punishment" and "treatment". It is a fact that a much higher proportion of the inmates in prisons have mental disorders compared with the population outside prison (Cramer, 2016). To support the mentally ill inmates, and reinforce their capacity of resocialisation, it is crucial that the staff of different service providing institutions (e.g. specialised mental health and prison services) engage in

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interagency collaboration to gain proper knowledge about the inmates' livelihoods, life situations and health problems (Lehtmets & Pont, 2014; Helsedirektoratet, 2016; Bjørngaard et al., 2009). However, the complexity and unpredictability of interagency collaboration and knowledge management create a need to shed light on the challenges faced by the professionals working with inmates with mental health problems. As a consequence, calls for more effective models of collaboration have been made (Fenge et al., 2014; Hean et al., 2017).

In this chapter, we take an activity-theoretical approach to identify the boundaries and collaboration and integration needs between different service providers. The activity-theoretical approach has been chosen as it helps identify the tensions which can act as triggers for future organisational change (Engeström, 2008; Kajamaa, 2011; Engeström & Kärkkäinen, 1995). We pay special attention to compartmentalisation of practices by which we mean the work that takes place in separated, isolated compartments, which invariably results in poor coordination and problems in service provision. While acknowledging the contradictory dynamics of organisational life, we aim to uncover challenges manifested in the interaction between the specialised mental health service outside the prison, the primary health service located in the prison, and the prison services, including the inmates as subjects of our study.

Theoretical–Methodological Framework

Cultural-historical activity theory (Leont'ev, 1978; Engeström et al., 1999; Sannino et al., 2009; Engeström & Sannino, 2010; Engeström, 2015), applied in this chapter, perceives tensions in work practices as manifestations of historically accumulated, systemic contradictions (Engeström & Sannino, 2011; Engeström, 2000). Contradictions are considered to be products of the socio-economic activities in which they are embedded. Further, "contradictions act as driving forces of change as they generate tensions, disturbances and innovative attempts for development in social action" (Kerosuo et al., 2010, p. 115). Activity theory helps us to construct a contextualised view in which social activities

are carried out by a multitude of interacting individuals, groups and networks. The participants in each of these have their own worldviews, that may conflict with or be complementary to the other voices and opinions represented (Sannino et al., 2016; Engeström, 2016).

Our focus in this chapter is on the compartmentalisation of service provision practices for the inmates. According to the Cambridge Dictionary, compartmentalisation means: "to separate something into parts and not allow those parts to mix together". Using this definition as an entry point, "*compartmentalised practice*" is here understood as those challenges that emerge when information, meanings, awareness, facts, etc., are being separated into isolated psychological or physical compartments. Compartmentalisation is likely to complicate the everyday interactions between the mentally ill inmates and different service providers connected to the prison setting. From an activity-theoretical perspective, compartmentalisation causes tensions and poor coordination of the activity between the different systems, likely leading to fragmentation of the overall object of their collective activity, that is the rehabilitation and better quality of life of the mentally ill inmates.

"*Compartmentalised expertise*" can be seen as historically shaped and transferred through an apprentice-like relationship between a particular profession and those learning this profession (Engeström, 2018). In addition to the development of one's own expertise, a professional must work with partners from other disciplines. To do so, interagency work is needed, and it requires collaborative and transformative competencies developed in response to the ever-changing conditions of professional and organisational life. These competencies are "…inherently heterogeneous and increasingly dependent on crossing boundaries, generating hybrids, and forming alliances across contexts and domains. There is no universally valid, homogenous, self-sufficient expertise" (Engeström, 2018, p. 14). The notion of this "*boundary crossing expertise*" is here positioned within a collective object-oriented activity, which flexibly transcends both professional and organisational boundaries (Edwards & Kinti, 2010; Engeström, 2018).

Most of the data analysed for this chapter were collected by carrying out ethnographic fieldwork in a low-security prison in South-Eastern Norway. The data were collected by interviewing and observing inmates

and prison staff, and primary health service staff located in the prison.[1] Other informants related to this local field of inquiry were a physician working part-time in the prison and a first-line prison psychiatrist working in a high-security prison situated nearby. Some of the data were collected from a local community mental health centre by interviewing various staff of that institution. The aim of our data collection was to gather insider perspectives on what goes on, who or what is involved, and why, to see issues from the standpoint of the informant.

The ethnographic data of the informants were assembled as an "extended" case study constructed on the basis of a series of connected cases occurring within prison life (Gluckman, 2006; Mitchell, 2006). In our analysis, we have applied the activity theory (Engeström, 2015. See Chapters 1 and 8 for an explanation of this conceptual framework) and a narrative approach (Mishler, 1986; Czarniawska, 2007). The data for each case were organised into "mirrors of prison life". A mirror can be seen as a critical account, or explanation of a concrete activity, a situation or a cluster of activities, included in our ethnographic data, and analysed and interpreted by us in terms of activity systems, their tensions and organisational learning.

On this basis, we have presented our findings in four sections. The first section is based on an account given by a frontline psychiatrist working in a high-security prison. Her narrative describes the shortage of psychiatric beds and the lack of specialised psychiatric knowledge about mentally ill inmates. The second section focuses on the low-security prison and depicts how an inmate, who was an addict and suffered from an antisocial personality disorder when imprisoned, negotiates the challenges of prison life and enacts different forms of resocialisation. The third section is concerned with the prison staff and the primary health staff located in the low-security setting. It illustrates their views on tensions about interagency collaboration with the local community

[1] The primary health service located in the prison is a result of reorganisation of prison services that has been taking place in Norway since 1969. According to the ideology of reorganisation, whenever possible, inmates should receive the same level of service as citizens living outside the prison. Consequently, the primary health service of the municipality was "imported" into the prison where it constitutes a separate service unit organised and financed by the municipality and collaborating closely with other prison services on a daily basis (Fridhov & Langelid, 2017).

mental health centre (in Norwegian: Distriktspsykiatrisk Senter (DPS)). The fourth section presents the problems of collaboration as described by the staff of the DPS.

First Mirror: The Psychiatrist

During interviewing we used snowballing techniques in which each informant was asked to name two to three other people in the same professional network. These other people were then included in the interview sample, the human landscape of ethnographic research stretching well beyond the local field site. Several informants named an experienced first-line psychiatrist working in a high-security prison, who had formerly risk-assessed many of the inmates presently populating the low-security prison in which we carried out fieldwork. The informants pointed out that this psychiatrist had extensive knowledge about the mental illnesses of inmates and the collaboration with the psychiatric system outside the prison. Thus, the psychiatrist was interviewed, and she turned out to have strong ties to the research setting and was an informant providing vital contextualisation (see also Gluckman, 2006). When asked about the collaboration between the prison service and the mental health service she explained:

> *Inmates can also be psychotic and then we have a problem. It is the health service in the prison that makes the referral to the community mental health centre. According to my experience, if the mentally ill inmate perhaps is admitted to that centre, the staff show little interest in our category of patients. I have spent years getting inmates with a treatment need hospitalised. Recently, we filed a complaint in the regional court (Fylkesmannen) about mistreatment of a mentally ill inmate. He has been diagnosed with chronic schizophrenia. In the past, he was hospitalised several times but every time the therapists assessed his symptoms to be simulations (…) I think there are several reasons for these conditions. Firstly, there are few places in psychiatry where they work a lot with inmates and therefore have the necessary knowledge about prison conditions. I also think that there exists a basic capacity problem in psychiatry. There are not enough beds. Think about this: in 1960 there were 18,000*

> *psychiatric beds in the whole country; today that figure is down to 3,500 beds*. (Interview with psychiatrist, 20 October 2017)

This excerpt identifies an interface riddled by tensions, in particular regarding what should have been the shared object of activity of the specialised mental health service and the primary health service located in the prison: the treatment of the prisoner. The psychiatrist accounts for the consequences of compartmentalised division of labour as follows. She describes the vast amount of resources, sometimes used in vain, to get inmates hospitalised and the mistreatment of mentally ill inmates, in situations lacking interagency collaboration. Officially, the collaboration between primary health service located in the prison and the specialised mental health service is regulated by formal agreements between institutions but the operationalisation of these is less clear-cut. The psychiatrist calls for better treatment of mentally ill inmates and her account comprises several constraining factors of interagency collaboration, including the lack of psychiatric beds and a deficiency of psychiatric knowledge about prisons and inmates.

In this mirror, the psychiatrist describes how different rationalities clash when the specialised mental health service and the primary health service located in the prison attempt to deal with the object of rehabilitation: the troubled inmate with a mental disorder. The lack of expertise in the specialised mental health service when it comes to working with prisoners hinders object-oriented care provision, blocking the admission to the psychiatric hospital ward. If admission *is* eventually granted, their lack of expertise in dealing with prisoners impacts on the care they receive while in hospital. According to the psychiatrist, the lack of boundary crossing knowledge in the specialised mental health services and the lack of collaboration with the primary health service located in the prison makes the likelihood of the inmate's recovery uncertain. Figure 3.1 presents elements of the psychiatrist's activity system. In the figure, the narrated disturbances are indicated with lightning arrows between the elements of this activity system.

The tensions analysed in the activity system (in Fig. 3.1) are indicative of compartmentalised psychiatric expertise. It seems counterproductive inasmuch as it closes in on itself, and the psychiatrist cannot reach out to

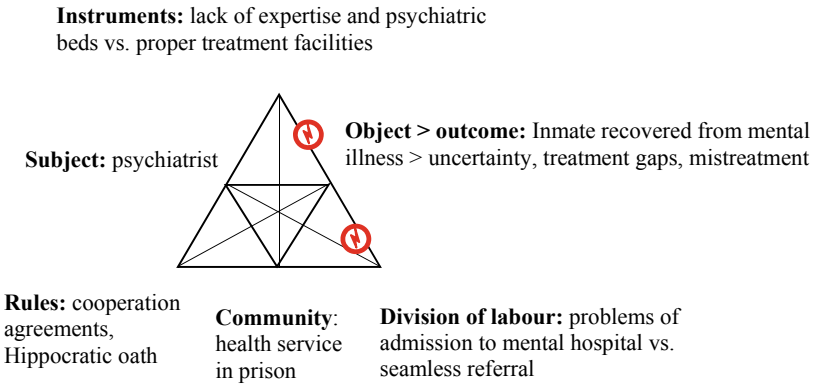

Fig. 3.1 The disturbances recounted by the first-line prison psychiatrist

other actors knowledgeable on the inmate's situation (e.g. a psychiatrist reaching out to a prison officer in order to incorporate into a care plan his expertise on individual inmates with mental disorders). In this context, the compartmentalised practices produce mismatches which invariably result in poor communication and mistakes, not least because of the blocked coordination and information flow. The constrained interagency collaboration presumably creates frustrations, confusion and discoordination on both sides, among staff of the prison and the staff of the mental hospital.

The lack of psychiatric beds illustrates a lack of resources. However, it is something which can be reduced (but not eliminated) by improved organisational collaboration, e.g. if more inmates receive psychiatric treatment in the prison. Similarly, if the specialised mental health services lack qualified personnel due to economic constraints, the shortage of staff cannot be balanced entirely by improvements between the prison and mental health service collaborations. Despite the collaboration intentions, lack of resources will continue to limit the system's treatment capacity, and indirectly its institutional "willingness" to admit mentally ill inmates. In fact, resource shortages may limit collaboration efforts in the first place as the compartmentalisation of treatment and work practices of the mental health service often emerge when the psychiatric system is pressured to meet the cost-efficiency requirements of the health

care sector. In this light, policy analysis made by the Norwegian Medical Association (NMA) shows how certain patient groups may be prioritised when budget cuts are made (Den norske legeforening, 2018) and the prison population, supposedly because of social stigma, is unlikely to be one of the priority groups.

Second Mirror: The Inmate

Exploring how inmates make sense of the world around them, give meaning to it and socialise with others requires some reflections on our ethnographic research process. Collecting information on mentally vulnerable inmates is naturally a sensitive issue. Prison staff members were not permitted to pass information to us on the inmates, so it was difficult for us to identify the interviewees, and get in contact with them. To overcome these difficulties, a member of our research team became an apprentice in the prison storage and was trained by a supervisor-inmate. It allowed him to follow the daily routines of prison life, and via the combined role of an apprentice-researcher, staying in the field for a prolonged period (Downey et al., 2015). The apprenticeship meant that the researcher's presence gained legitimacy and generated trust. Then, the inmates began to exchange information with him on their life course experiences, including mental vulnerability.

We have created the following mirror by selecting one of the interviewed inmate's narrative for an in-depth analysis. The narrative is based on participant observations and several interviews with the inmate who had a double diagnosis (drug addiction and antisocial personality disorder) when he began serving his sentence for having committed a homicide. Besides showing the common connection between crime, drug abuse and mental health problems (Friestad & Kjelsberg, 2009; Cramer, 2016), these ethnographic data demonstrate how an individual inmate can experience problems related to the poor collaboration between the prison services and the mental health services.

In his mirror, the inmate emphasised the good relationship he established with a prison officer and a nurse from the primary health service located in the prison. Both professionals were therapeutically trained and

supported him with his much-needed reflective therapy through weekly conversations (Andersen, 1987, 2005; Anderson, 2003; Wagner, 2009). During the first part of imprisonment, the inmate had not had any contact with his family, including his children. The reflective therapy helped him to ease his anxiety, and his fears related to being reunited with his family. To restore the relationship with his family, the inmate made a phone call to his mother and his experience of this first call was one of success. Afterwards, while on leave from the prison, he made several family visits to his hometown and managed to reactivate his family bonds. We asked him if the visits also reactivated contacts with his former criminal friends, to which he responded in the following way:

> *No, not at all. Several things have happened to my old environment. First, most of these friends come from a city not located in the region where my mother lives. Second, many of my former friends died of an overdose, have committed suicide or are imprisoned. Third, other friends have been through a change process similar to mine. That is good. Anyhow, I have a family and all family members have been so caring and helpful. I am very lucky in that regard*. (Interview with inmate, 6 October 2017)

This excerpt shows how the inmate was trying to create distance between himself and his criminal past by recounting the unpleasant destinies of former accomplices. It also illustrates the importance of family relations to him. Furthermore, during the interview the inmate explained how renewal of family ties supported him in dealing with some of his mental problems, such as the guilt about the terrible things he had done, and the shame generated by his bad self-image. He recounted how he had expressed remorse and apologised to his family and children. They forgave him and the process contributed to repairing the damage he had caused. In terms of resocialisation, his reconfigured social identity as a son, a brother and a father, added important aspects to his personality and later became vital elements of his recovery.

The inmate's gradual recovery, psychologically and socially, was also supported by his vocational development when he started as an apprentice in the prison's mechanical workshop. His learning curve was quite steep because most metalwork had to be made within a margin of

one-tenth of a millimetre. He performed his work according to the instructions given by the workshop manager. However, the guidance provided by teachers and required considerable cognitive efforts for him. The workshop activities involved cognitive exercises like experimentation, modelling, problem-solving and testing through maintaining the vehicles. The work to ensure the functionality and reliability of the engines, including their mechanical, hydraulic and electrical systems, also demanded theoretical knowledge (contained in drawings and manuals) to be used through the operation of welding equipment as well as lathes and drilling and milling machines. Consequently, the inmate's participation in the prison's education and work activities was stimulating and productive, enabling him to become a skilled and certified motorcycle (MC) mechanic.

The inmate's new status of being a skilled mechanic gave him the prospect of resocialisation. The change in the inmate's occupational status, relative to his previous position as an unskilled worker, can possibly lead to a higher social stratum in the future, and he might become an employed worker. Presumably, the inmate hoped to convert this new "social mobility" into a higher degree of commitment to civilian life. Moreover, the inmate explained that he had a job arrangement with an employer that would allow him to commence wage labour in a mechanical workshop following his release from prison. He had organised this employment plan himself, without support from the public jobcentre and it shows us something about the inmate's vigour and determination.

In his resocialisation, attention needs to be drawn to the relationship between personal and vocational learning, in other words, how his social identity and work identity had become interlinked. The inmate's resocialisation meant that he was learning new vocational skills. Via these skills, he adapted norms, values and attitudes that would ease his reintegration into the labour market and the private sphere. These processes of resocialisation are both sociocultural *and* material (Engeström, 2016), as they enhance the individual's capacity to handle psychological challenges as well as material objects and practical work activities. Analytically, participation in activities of the prison workshop had encouraged the inmate to embark on new cycles of resocialisation covering the distance between

his actual imprisonment and the societal prospect of reintegration into civil society.

For multiple reasons, the case of this inmate also illustrates a tension-laden journey, with some tensions being created by his need to overcome his own drug addiction. The treatment of drug addiction was a core aim written into the premises of his homicide sentence. However, as the inmate pointed out in an interview, it was difficult to be admitted into the drug treatment programme. The staff of the primary health service located in the prison supported the inmate with a medical referral focusing on the inmate's urgent need for the drug treatment (only available outside prison), but the admission turned out to be an issue of long-term planning. It took four years for the inmate and the primary health staff located in the prison to get the referral through to the specialised psychiatric hospital ward outside the prison. To manage the crisis caused by lack of admission, the inmate showed a high degree of willpower, for example, when he continuously insisted on implementing the premises of his sentence, instructing him to embark on a detox programme, as demonstrated here:

> *In my opinion, there should be talks on drugs and rehabilitation, it is so important. I would recommend that inmates stand up for themselves and are outspoken, you do not achieve anything by sitting down and not saying anything. I am very satisfied that I did it because it led me on the right way, so stand up for yourself!* (Interview with inmate, 6 October 2017)

During the waiting period before getting treatment at the specialised hospital ward, the inmate tried to give up drugs on his own and steadily regained his motivation to rehabilitate, e.g. when he woke up one morning without withdrawal symptoms and a screaming nervous system. Despite the self-initiated change, he was still struggling with the effects of depression and questions of how to handle the risk of relapse in situations in which he was in contact with drug addicts in prison. He still needed to find ways/tools with which to hold onto his new "clean, crime free" identity and exert self-control that would help transformation from his old patterns of drug user identity and behaviour.

When after years of waiting the inmate eventually met a specialised consultant in the psychiatric hospital ward outside prison, he was told that it was unusual for them to treat a patient who was not an active drug user. The consultant, nevertheless, agreed to offer twelve consultations allowing the inmate to bring up topics on his own initiative. In the final evaluation, the consultant noted that the patient was motivated and had achieved good emotional control. The consultant recommended further conversational treatment in prison to facilitate transition to civilian life (Interview with inmate, 6 October 2017). Figure 3.2 presents the elements of the inmate's activity system. The challenges within this system are indicated with a lightning arrow.

Although the inmate had to wait four years for the treatment of his drug addiction and mental illness, the period became a source of change. The long wait spurred both the inmate and the primary health staff located in the prison into collaborating with each other. Their collaboration included the reflective therapy carried out in the prison in the interim, and it reduced and at last dissolved his antisocial personality disorder. It had expanded the inmate's resocialisation and reflective capability to make plans and independent decisions. It contributed not only

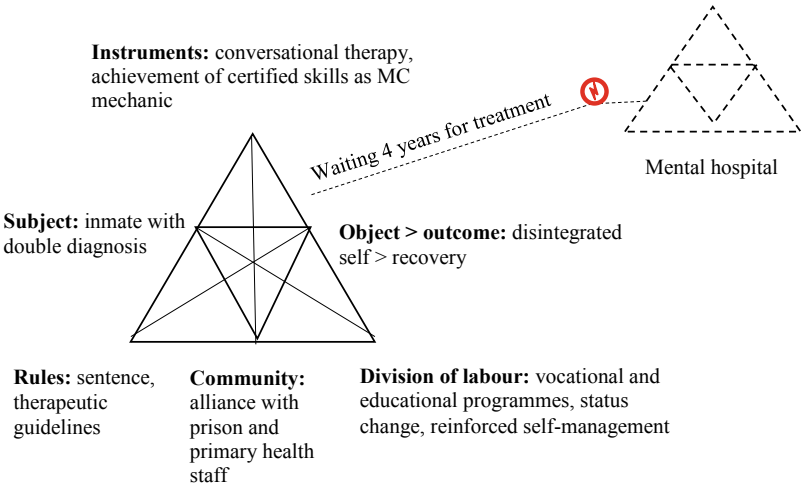

Fig. 3.2 The strengths and vulnerabilities experienced by the inmate

to his mental rehabilitation but also enabled him to be more self-directed and successful in his future drug treatment.

According to the inmate, it was the trust shown to him by the prison officer and the primary health nurse (who supported him with reflective therapy), which paved the way for the development of his life skills. For example, the inmate narrated how their trust enabled him to distance himself from the subculture of drug trade and the hypermasculine hierarchy, the latter known as a general feature of prison life (see also Abrahamsen, 2017; Ricciardelli et al., 2015; Viggiani, 2012). By freeing himself from the social group pressure, usually forcing inmates to follow a given frame of criminal norms of loyalty and toughness (see also Ricciardelli, 2015), the inmate demonstrated individuality and used his acquired knowledge and skills to navigate towards being a citizen with a normal livelihood. Through this process of individuation and change, the difficult situation of being imprisoned gained a new meaning embedded in a collectively generated vision, the societal discourse on resocialisation outlining a possible future outside the prison. However, had the inmate chosen to follow the existing and risk-prone prison subculture, this narrative would certainly have been very different, likely with negative outcomes.

Third Mirror: The Prison Authority and the Primary Health Staff

Staff are important members of the prison community and we chose two informants from our sample, a deputy head and a primary health nurse. The interview strategy we employed in the prison involved formal interviews based on a semi-structured questionnaire. Whenever needed, the formal interview schedule was supplemented with informal conversations, follow-up interviews and e-mail correspondence. Besides participant observation, for example, at interagency meetings, interviewing was supplemented with other forms of human communication (Jorgensen, 1989), including document analysis of work programmes, minutes of meetings, evaluation of inmates, etc. In this way, fieldwork generated a vast amount of information, from which we selected the

most illuminating data and analysed it with the help of the activity system model.

Our ethnographic research in the prison enjoyed the support of the local deputy head who in many ways helped us to establish an overview and get in contact with staff and inmates. Questioned about the prison population's mental illnesses, he explained that although they rarely suffer from psychosis, they are often diagnosed with other mental disorders. Furthermore, we invited the deputy head to comment on the problems of interagency collaboration with the specialised psychiatric system outside the prison, previously narrated by the first-line psychiatrist working in a high-security prison. From the deputy head's standpoint, the collaborative problems he experiences are of another kind. Still, both the deputy head, and later the primary health nurse, described interagency collaboration with the specialised psychiatric sector as difficult. It seems that the deputy head and the primary health nurse working in the prison shared day-to-day experiences concerning cooperation between the different service providers. Here the issue of collaboration is elaborated by the primary health nurse:

> *What we as health service staff experience is the big difference in how the DPS treats the patients after a white paper reform was carried out a couple of years ago. Prior to the reform, more inmates were admitted for polyclinical treatment at DPS. Presently, our experience is that the specialised psychiatric service is occupied with patient assessment and diagnosis while actual treatment is expected to be carried out by the primary health service of the municipality, in our case the health service of the prison. We do not feel competent and qualified to handle the more difficult cases of mental disorder occurring in the prison. Although the DPS is responsible for providing the primary health service with guidance, our need for supervision, methods and tools is hardly ever met*. (Mail correspondence with nurse, 2 August 2018)

The reported problems are indications of compartmentalised practice at the interface between the primary health service located in the prison and the DPS. The aim of the governmental white paper reform referred to by the nurse, was to improve collaborative interaction between public sectors and institutions. The regulative policy has been termed the "LEON" principle. It specifies that treatment must be carried out at the

lowest possible level of effective care. Accordingly, it is not the diagnosis that determines where the patient receives treatment. Instead, priority is given to factors such as the patient's clinical condition, the treatment needed and qualifications of the available therapist (Social- og helsedirektoratet, 2006, p. 9). The "LEON" principle is associated with other parts of the health legislation and regional cooperation agreements.

Yet, in some circumstances, as articulated by the primary health nurse working in the prison, the regulative policy has produced coordination problems and treatment gaps. For example, reversal of an inmate's referral to the primary health service in the prison is met with resentment among the health staff, since they do not possess the necessary expertise and instruments. In this light, the LEON principle does not seem to reduce the compartmentalisation of psychiatric expertise, and the present state of affairs blocks potential efforts to share, through procedures of exchange and distribution, the specialised psychiatric knowledge and treatment methods. The primary health nurse's statements and the challenges within this system are summarised in Fig. 3.3.

The nurse's viewpoint is formed by her experiences of adverse effects of compartmentalisation, for example the unmet need for guidance and

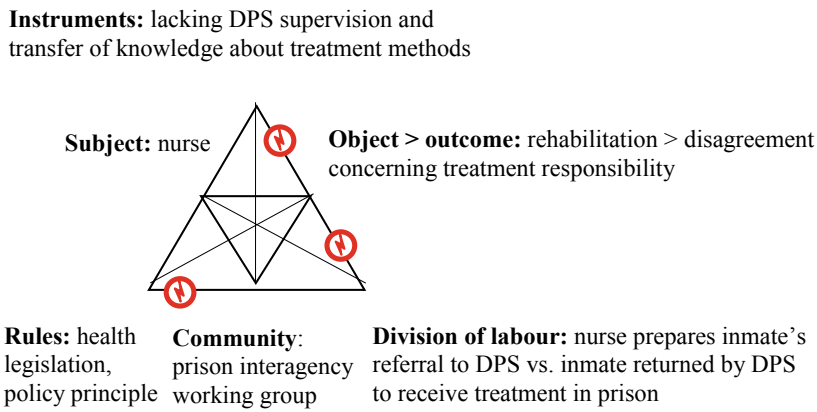

Fig. 3.3 Tensions narrated by the primary health nurse located in the prison

knowledge sharing. Shortage of material resources and facilities necessary for psychiatric treatment might add another range of tensions to the relationship between the primary health service located in the prison and the DPS. Adverse effects might also create unintended consequences, as illustrated in a follow-up interview. Here the prison's primary health nurse explained how she sometimes requested that the DPS carry out a risk assessment of a mentally ill inmate. The reason for the request could be that the inmate was violent or otherwise dangerous to himself and his surroundings. However, such requests were often denied by the DPS. Without a risk assessment, the prison authority had to relocate the inmate by transferring him to a high-security prison possessing the necessary means to pacify that type of unruly behaviour. The example demonstrates stakeholders' experiences generated through the struggle for access to assessment capacity of the DPS, and the situation illustrates a latent need to develop interagency collaboration and boundary-crossing expertise.

Fourth Mirror: The DPS' Staff

To capture the psychiatric health care provider's standpoints and gather more information on the multiple perspectives, we now describe the DPS' organisational setup and experiences expressed by some staff members. It was not without challenges to get in contact with the relevant staff at DPS. When doing fieldwork in the prison, our research team tried to identify the primary health service's contacts at the DPS. It turned out to be difficult to get the names, perhaps due to confusion as to whom the actual contact persons were. The situation conveyed an impression of a messy "interaction order". On second thought, this could also be a sign of misunderstandings, due to the limited knowledge of newly employed staff or failure on our behalf to establish the necessary rapport. In this light, arbitrariness and contingent conditions can affect the gathering of accurate information, which we tried to handle by building trust and cooperation as well as cross-validating data. The incident also shows how difficult it is for outsiders, say researchers, to

navigate through unknown interconnected networks and arenas (Glaeser, 2006).

Regarding the organisation of DPS, it is regulated according to law and government guidelines of specialised health services (Helsedirektoratet, 2014). The organisation is divided into several teams covering outpatient clinics, outreach teams and inpatient treatment. Health personnel consists of various professionals, such as a psychologist, psychiatrist, physiotherapist, social worker and specialised nurse. The staff occupy a range of administrative and medical positions and function as the psychiatric system's gatekeepers. Their main responsibilities include assessment of multiple patient-needs and diagnostic work. In addition, they provide services to and cooperate with regional hospitals and various institutions at the local level. The DPS' own summary of the organisational challenges comprises better access to specialised services, recruitment of professional staff qualified to handle given tasks and responsibilities, improvement of cooperation with external partners and strengthening of the professional medical expertise (Social- og helsedirektoratet, 2006).

A psychologist and a specialised nurse from two different teams at the DPS explained the present collaboration with the primary health service located in the prison by recalling positive experiences and the good job done by the health staff. However, they also recalled some inadequacies. The shortcomings involve imprecise information contained in the referral of mentally ill inmates and too few joint meetings and shared goals of treatment. Both informants suggested that collaboration could be improved by exchanges of information and the development of a better-shared understanding of the mental health problem (Interview with psychologist, 22 November 2017; interview with nurse, 24 November 2017). A physician (GP), working part-time in the primary health service located in the prison, added to the picture by stating that participation in follow-up meetings at DPS sometimes were irregular due to logistical difficulties (Interview with GP, 22. November 2017). Figure 3.4 presents our activity-theoretical interpretation of the interviews with the psychologist and the specialised nurse, and the problems of collaboration they expressed.

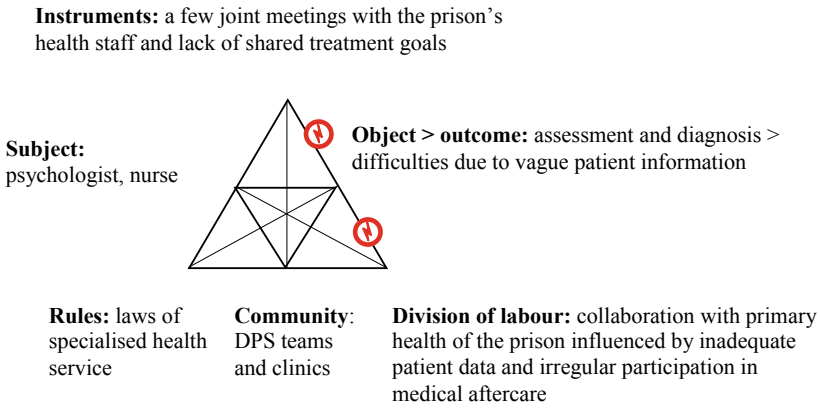

Fig. 3.4 The troubles of collaboration expressed by the DPS' staff

There are several reasons behind the troublesome interagency collaboration. A mismatch of insufficient information about the patient seemingly affects the psychiatric assessment capacity. Inadequate documentation at several levels as well as irregular participation by various primary health staff constitute other factors of constraint. The critical topics of too few joint meetings and the shortage of common treatment goals indicate that some instruments of collaboration are missing. In terms of analysis, the criss-crossing, flux and interweaving of tensions frame a situation in which organisational cohesion exists side by side with drivers of organisational transformation. We traced a possible new pattern of interaction through asking questions about the solutions to the troubles described. When asked about how the relationship between the primary health service located in the prison and the DPS could be developed in the future, the psychologist said:

> *Yes, one thing is collaboration. In my opinion we could establish an arena, a meeting place between [name of prison] and the psychiatry…I think that therapists from [DPS] polyclinic and the emergency team would be interested in participating. The prison staff could benefit from communications with the therapists of the psychiatry and receive education…in criminal psychology, how to talk to patients with psychiatric problems, I think.* (Interview with psychologist, 22. November 2017)

In these excerpts, the psychologist articulates a new scenario. In our interpretation, he presents the seeds of change by calling for more refined collaboration to overcome the compartmentalised practices. In the proposal put forward by the DPS psychologist, we sense a need for the development of interagency expertise that explores opportunities and reorganises the collaboration between the two service providers. Establishment of a boundary crossing meeting place could be realised through network activities and adhoccratic modes of working. Such a collaborative endeavour would be characterised by flexible arrangements and the ability to handle unexpected things. The organisational platform deviates from a professional bureaucracy and is closer to an innovative organisation with decentralised decision making and tasks continuously redefined and adjusted according to the ever changing needs. Presumably, coproduction within this context might bring about a high level of conflict but the conflicts are seen as useful, or even desirable, and act as sources of development. Exactly how this type of boundary crossing knowledge exchange and reorganisation (Engeström, 2018) should be enacted is difficult to predict. Questioning and problematising the current work practices maybe seen as the first step towards this direction.

Discussion

From an activity-theoretical standpoint, Fig. 3.5 addresses the key topics of compartmentalisation and boundary-crossing expertise by illustrating the interacting activity systems of the service providers involved, the primary health service located in the prison in alliance with the prison authority, and the specialised mental health service, DPS. The activity systems of the inmate and the first-line psychiatrist working in a high-security prison are not included, but they remain important cases for cross-references and background knowledge. Figure 3.5 highlights the inadequacy of the existing methods and instruments for sharing information across services, which then complicates the distribution of treatment responsibility between the two services. For example, the staff of the primary health service located in the prison lack treatment guidelines and treatment competencies, skills “belonging” to actors of the activity

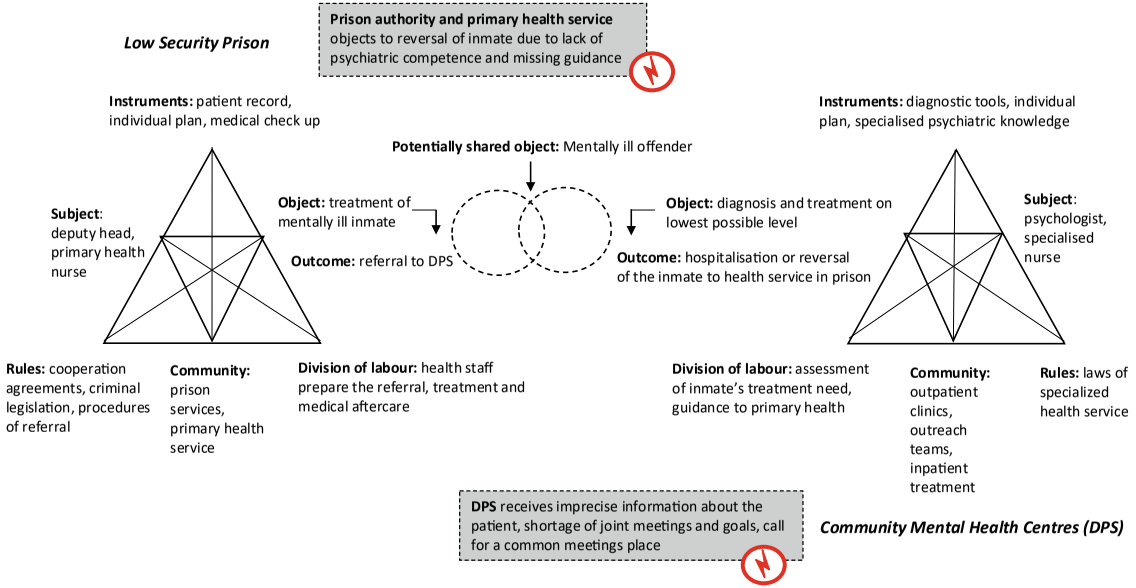

Fig. 3.5 Tension between the primary health service in the prison and the DPS

system of the DPS. Moreover, what could have been shared tools, such as medical referrals, are not always an issue of collaboration between the activity systems. Similarly, there does not seem to be a well-defined division of labour and the unclear interface often hinders collaboration.

Our research team had the opportunity to discuss the findings presented in the figure with the involved informants on three occasions: one seminar at which the prison staff and the staff of the primary health service were present, and two workshops, held in the prison, at which staff of the DPS also participated. On all occasions, the participants validated the ethnographic data and the way we had "mirrored" their interviews reflecting troubles of collaboration. The participants did not try to blame the professional groups "in the other camp" for the problems. For example, the prison staff did not articulate the problem of collaboration as one belonging to the municipality because that institution organises the primary health service located in the prison. In fact, all practitioners acknowledged the interagency tensions as a shared problematic not confined to a particular institution or sector. They expressed a professional sense of social responsibility reaching beyond their own confinements in order to solve the problem.

In general, the practitioners' feedback on the seminar and workshops corroborated our research results, saying that the interagency tensions seemed not to arise from the wrong activity (or inactivity) of individual actors or professions. Neither are they the result of miss-matching expectations. Primarily, they are the accumulated constraints caused by organisational compartmentalisation and lack of boundary-crossing expertise. It is problematic that the primary health service located in the prison and DPS function as two separate compartments, not having a shared understanding of the object of collective activity (the treatment of the mentally ill inmate with the aim of enhancing the quality of life). In the worst-case scenario, the inmate falls "between" the two institutions without receiving qualified treatment. This compartmentalisation and predicament then leaves some individual inmates in a stalemate characterised by ambiguity and uncertainty.

In terms of theoretical application, our research findings on constrained processes support a long-standing ethnographic proposition concerning two mechanisms underlying the development of social

systems and organisations, namely one of fission and one of fusion (Gluckman, 1958). It should be noted that the compartmentalised expertise of both the specialised psychiatric service and the primary health service located in the prison yields certain benefits alongside the abovementioned constraints. Professional actors convey strong vocational identities, and the meaningfulness of their daily work and feelings of belongingness, loyalty and commitment are embedded in the practices customary to their own profession and location. Further, the compartmentalised expertise often accommodates different interests and objects within the organisation and tends to produce in-group norms and legitimacy of the workplace—thereby creating effects of fusion. At the same time, however, the professionals may underestimate the need for collaboration and information sharing with those representing other institutions and professional perspectives. For this reason, the more compartmentalised an organisation is, the more difficult the interagency collaboration will be because it limits the interaction of the practitioners. In our view, this pattern shows effects of fission which tend to rupture collaborative efforts and organisational integration (Showers et al., 2004; Amiot et al., 2017).

Conclusions

In this chapter, we have provided multiple "mirrors" expressed by various informants related to the area of prison life. The mirrors have focused on organisational compartmentalisation and its negative consequences, such as the tensions in collaboration between the primary health service located in the prison and the specialised mental health service of DPS. The compartmentalisation is often related to hierarchical and bureaucratic modes of working, such as the privileging of knowledge exchanges between accredited professionals and institutions accorded with recognised authority and status. At the practical level, however, the compartmentalisation of work practices and knowledge disparities may cause problems, such as imprecise referrals information, lack of transfer of psychiatric guidance, rejected risk assessment of mentally ill inmates etc.

Finding powerful solutions to organisational tensions and contradictions requires collective explication and analysis (Engeström, 2018). We have attempted this by constructing "mirrors". These mirrors potentially facilitate organisational change and learning because we hope that the analysis depicted in these will help other researchers and practitioners to understand better the issues of boundaries, collaboration and expertise at the interfaces of prison, primary health service located in the prison and the mental health service at DPS.

From a developmental perspective, the tensions and disturbances identified in the ethnographic data may function as triggers for organisational change and learning, and the production of new ways of working (Engeström, 2008). The articulated need of a power-shift from professional bureaucracy to adhocracy, including multiciplinary teams consisting of primary health staff and DPS staff, exemplifies the future prospects. In this regard, the mirrors could be used as stimuli in participatory development workshops, such as the Change Laboratory, to facilitate dialogue and collaborative learning (see Virkkunen & Newnham, 2013; Hean et al., 2020, Chapters 1 and 8).

In boundary-crossing interventions of this kind, the individual inmate's self-knowledge and personal resources need to be included among other stakeholder voices and interests. In other words, such concerted efforts may engender the interagency competencies and reorganisation that are needed. They may also create an opportunity for emancipatory projects to emerge from below, such as "ad hoc alliances" through which mentally ill inmates are provided with an opportunity to participate as an expert in their own treatment and decision-making processes related to recovery and resocialisation. This type of expansive learning process might create innovative practices and support flexible collaboration.

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