Joint activity systems within the boundary space between mental health and correctional services: the leadership perspective

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Background

Mental illness is high in prison populations internationally (Fazel & Danesh, 2002) and is one risk factor directly and indirectly linked to reoffending rates (Armstrong, 2012; Sapouna, 2015) (Chang, Larsson, Lichtenstein, & Fazel, 2015)(Skeem & Peterson, 2011). Specialised mental health and correctional services are required to collaborate to address this and the importance of this kind of interagency working is recognized by the Europe wide Justice Cooperation Network, (2012). Despite their recommendations to optimize interagency working, little is known about what characterises collaborative practice in this context. The aim of this paper is to build an understanding of this collaborative activity using cultural historical activity systems theory as an underpinning and the joint activity of mental health and prison services in the Norwegian context as a case study. This insight will guide future interventions designed to enhance joint working between these highly differentiated and often fragmented systems and improve the mental health of offenders in the long term.

The Norwegian context

In the Norwegian context, reoffending rates are amongst the lowest in the world but 20% of offenders will still receive a new conviction within two years (Kristoffersen, 2013). The correctional services (CS) take a strong rehabilitation and reintegration approach to reducing reoffending rates, but the success of any intervention is mediated by the mental health of the offender. This is a concern as mental illness impacts on 92% of Norwegian offenders (HelseSørØst, 2014), an issue shared with many other national prison populations (Fazel & Danesh, 2002).

To maximise the success of mental health treatments, and offender rehabilitation in general, the Norwegian Correctional system view offenders as having the right to receive the same services as the wider population (Norwegian Ministry of Justice and the Police, 2008). To achieve this *principle of normality,* nurses and prison doctors, employed by local municipality, and mental health professionals employed by specialised mental health services (MHS) in regional hospitals, who provide services to the general population, also offer mental health and substance misuse services to offenders on a part or full time basis. Further, a reintegration guarantee is in place in national legislation (Sverdrup, 2013; Armstrong 2012;) that obliges prison services to work with offenders to prepare for their release, e.g., gaining them access to employment, education, suitable housing accommodation, some type of income, medical services, addiction treatment services and debt counselling. Prisons and multiple health and welfare services work together to deliver this and co-ordination posts (tilbakeføringkoordinator-TFK) have been introduced to coordinate this collaborative activity at a systems level (Sverdrup, 2013). The interagency working and learning in the MHS/CS environment that these coordinators encounter is complex and difficult to manage. Cultural historical Activity Systems theory (CHAT) can be used to make sense of this complexity (Engeström, 2001).

Third generation cultural historical activity theory as a cognitive tool

Cultural Historical Activity Systems Theory (CHAT) framework is an evolution of sociocultural learning theory (Vygotsky, 1978) in which the actions of individuals are described as mediated by cultural artefacts. CHAT expands this concept to suggest that the meaning we make of an activity (the object-Figure 1) is more than individuals' (or subject's-Figure 1) perceptions or socially mediated actions. Instead the system as a whole forms the unit of analysis, in which the multiple voices of the range of actors, or communities, within the system(s) are acknowledged. So too are cultural norms and rules that constrain or facilitate their activities and the ways in

which responsibilities or tasks are distributed amongst system actors. Whilst second generation CHAT focuses on the activity taking place within one system alone (e.g. the mental health services), third generational activity systems explores the overlap of two or more systems (e.g. interorganisational collaborative working between mental health and prison services) (Engeström, 2001). The explicit examination of contradictions, or dialectical tensions within the different components of the system highlighted in Figure 1 or between systems, form opportunities for learning and organizational growth (Engeström, 2007; Engeström & Sannino, 2011).

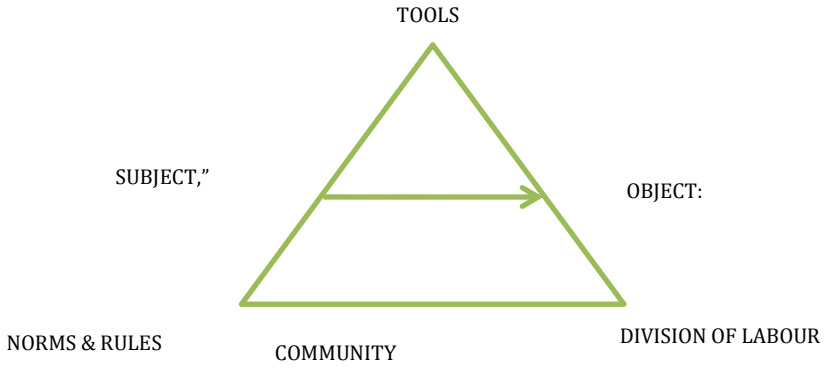

Figure 1: Generic Activity system (Engeström, 2007;

The point of overlap between two or more activity systems can be described in terms of the common motives shared by these separate systems or a shared problem space between systems where interorganisational learning and the transformation of interorganisational working can take place. It is a "space(s) where the resources from different practices are brought together to expand interpretations of multifaceted tasks, and not as barriers between the knowledge and motives that characterise specialist practices"(p34) (Edwards, 2011). It is possible within this space to identify and describe the presence of mediating artefacts that enable continuity between the systems (boundary objects) (Star, 1989).

Aim and Contribution of paper to CHAT subtheme of conference

This paper uses the third generation of Cultural-historical activity (CHAT) theory to examine the findings of a qualitative arm of a wider study (http://cordis.europa.eu/project/rcn/188119en.html) that explored the characteristics of collaborative working between correctional services (CS) and mental health services (MHS) in a Norwegian context. It seeks specifically to shed light on the

nature of the boundary space between the two MHS and CS services. It then raises the potential of change laboratory workshop models (Engeström, 2007), underpinned by CHAT, as a means of facilitating how mental health and criminal justice professionals may work together better in the future to coproduce socially innovative solutions to challenges they face in supporting the rehabilitation of mentally ill offenders.

Method

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 respondents were asked to identify other relevant leaders in the course of their interview (Patton, 2002).

The sample comprised 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.

Materials and data collection

A generic qualitative methodology was taken to the study, using semi-structured interviews as the method of data collection. The interview guide explored how the MHS work together with CS in practice. Specific prompts related to the range of services involved, specific structures in place to promote collaboration, the nature of relationships between services and what facilitated or constrained how they worked together.

The interviewer kept a reflective diary (Patton 2002) on the conduct of the interview. The interviews were at the workplace of respondents, 1-1½ hours in duration, except in one instance where a respondent chose to extend the duration of the interview voluntarily. The interviews were conducted in English by the first author but together with a Norwegian-speaking colleague (second author) to clarify language issues arising. In two cases, respondents requested a colleague to attend to assist with language issues.

Analysis

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

Summary and interpretation of main findings from a CHAT perspective

Six main themes characterised collaboration between mental health and correctional service system:

- The work goals and objectives salient to each system during collaborative interagency activity
- Moving into the boundary space
- Activity within the boundary space
- Tools mediating activity within the boundary space
- Norms and Rules within the boundary space
- Contradictions within the boundary space

- Contradictions preventing entry into boundary space

Work goals and objectives salient in the collaborations between MHS and CS

Three overlapping activity systems are apparent in the CS and MHS leader interviews: that of the MHS, the CS and of the offender themselves. Several categories in the analysis made up this theme and related to a description of these systems, with leaders in the MHS and CS discussing firstly their own activity system's work goals and objectives most salient to them when collaborating with the offender and/or other agencies.

Collaboration with other agencies is described by respondents as essential at all points in the offender's trajectory through the criminal justice system, but it was at the point when offenders are serving their sentence and when the aim of their rehabilitation and reintegration back into the community is a focus, that took precedence in their discussions.

Respondents describe their activities in categories that described their aim to *identify and prioritize offenders' needs* and then *Map and Mobilize resources* to address these needs*.* *Engaging the offender* is paramount to the success of these two activities. The nature, and emphasis placed on different elements of these activities varied depending on whether the individual had front line or more leadership/administrative duties but the underpinning objectives of their activities remain basically the same.

- The *identification and prioritisation of offenders needs*

When professionals engage in the *identification and prioritisation of offenders needs,* this comprises a process of familiarisation with either the individualised needs of each offender or the more generalised needs of a group of offenders. At the level of the individual offender, this familiarisation occurs through the professional actively soliciting information from the offender uniprofessionally (an interaction of offender and agency activity system but not between agency activity systems). For the prison staff, this may be identified during the offender's entrance interviews for example, when the offender is admitted to prison or by the offender raising the issue unsolicited (e.g., self referral to the prison nurse). For specialised mental health staff, identification of needs takes place when offenders are admitted to secure wards in the hospital after referral from prison staff or in active outreach activity when professionals from the MHS go into the prison on regular scheduled visits each week.

Respondents report offenders to have multiple, interdependent and changing needs, each difficult to untangle one from the other. Professionals, having limited resources, must prioritise these, dealing with the acute needs first before moving onto those that are longer term. Sheltered housing needs may take precedence over employment needs upon release of an offender with mental illness for example.

- *Addressing offender needs*

The second dimension of the activity described by respondent s is to address the identified needs. Professionals in the criminal justice system *map the offender's existing resources* (e.g., locating the offender's GP in the home municipality), and *mobilise* these by working with the offender to reestablish or repair these connections. They alternatively seek to establish new links to supplement the offender's support network.

if it is not acute then the whole thing will be put on hold and when they are getting ready to be released, just before they are released, we try to get the inmate to maybe call his psychologist, to say I'm coming back (commune, prison nurse)

Staff, in specialised services, explore the treatment that should be provided (e.g., medication, cognitive behavioural therapy) and where this treatment is best delivered (e.g., in prison or the hospital secure). At a systems level, leaders from both systems map existing services supporting particular groups of offender and seek to fill gaps in these services where these exist.

Its about reestablishing or maintaining…there can be broken relations. As part of the mapping it will be evident that there are a lot of things that have been present in the past which we can reestablish (probation social worker)

- *Engaging the offender*

Although the perspectives of offenders were not explored first hand in this study, the collaboration between the professional and the offender is central to all professionals participating in these interviews This collaboration is reported by respondents as being inhibited if the prison is not familiar with the offender**:** the assessment of offender's needs and referral for appropriate support is particularly difficult during early contact with the criminal justice system, when the motives and history of the offender is unknown. This is especially the case when acute conditions present

themselves and it is unclear the reasons behind offenders' disruptive behaviour and hence the appropriate course of action (e.g. is the offender pretending, withdrawing from drugs, mentally ill, afraid?).

Respondents describe the stay of an offender in prison as a valuable opportunity to work with offenders in a controlled environment. But no matter how good the collaborative efforts between professions and organisations in addressing the offenders rehabilitation needs and reintegration back into society, they recognise that the offender themselves is key to the success of these collaborations. Without their cooperation within the network, interorganisational and interprofessional collaboration efforts are doomed to fail: a GP in the home municipality, for example, may be engaged with the offender before release, but the offender may choose not to attend the scheduled appointment when on the outside; the offender may resort to substance misuse despite a substance misuse programme and housing provided may be abandoned in favour of homelessness or alternative accommodation; an offender may not accept their condition and fail to enrol in treatment programmes to resolve this. It is important therefore to build positive relations between the actors in the network and the offender, to develop feelings of trust and develop plans in which offender choice and ownership is paramount.

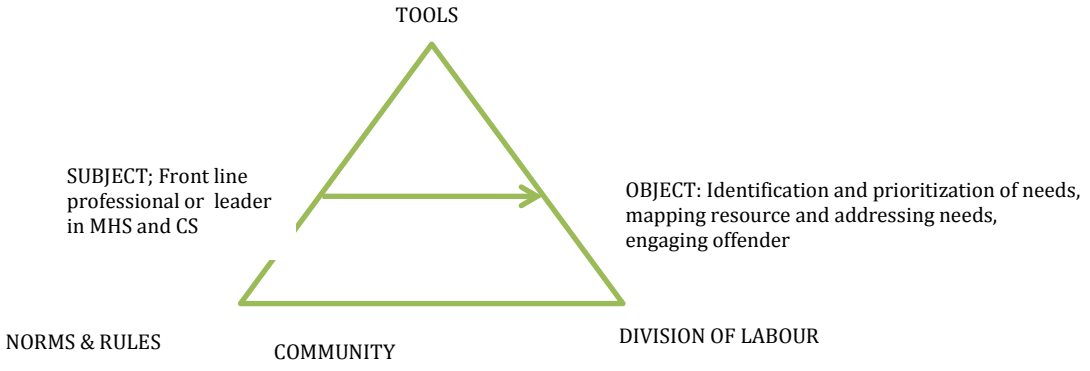

Figure 2: Main object of the MHS and CS activity systems respectively

Moving into the boundary space

Professionals from different systems describe being drawn together firstly through feelings of shared purpose and of facing similar challenges (for example the police and mental health services both need to deal with violent aggressive offenders). It occurs also when professionals recognise the importance of the skills and expertise of others to the delivery of their own work activity. This need for help is exacerbated

in situations when, at the level of the individual, the offender is in a state of crisis (often early on in incarceration). At a systems level, this occurs when there are critical gaps in service provision. The interdependence of goals drives collaboration between professionals, when they acknowledge they cannot stand alone, and this moves them into the boundary space where the two systems overlap (Figure 3). This interdependence is illustrated when professionals within the criminal justice system describe themselves as being uncertain about the best course of action when addressing the needs of an offender exhibiting aggressive or strange behaviours. This uncertainty drives them to seek help from mental health professionals.

We are not the experts. They are the experts We need their help……the health system is important and we cant do it alone (Prison lead)

Mental health professionals on the other hand are at times uncertain of the treatment to provide particular group of offenders and look to experts within their own field in other regions for novel ways to treat this group. Similarly, they may seek out assistance from other organisations when implementing their treatment programmes aimed at an offender group in a particular location (in the prison or municipality for example).

I want to say one thing before I forget it,,,,…you were talking about the municipality….. friendship between with municipality and specialized services. We want so much to get further …to get out in the municipality with this programme. How do we connect with the municipality after prison? (Mental health leader)

But for collaboration to occur, leaders recognise that people from other activity systems must enter the boundary space as well. Respondents express a desire for greater engagement of certain professions or organisations in the task of assessing and addressing the needs of offenders and express disappointment when this does not occur. At an individual level, they discuss the low motivation, commitment and attendance of individual professionals at leadership meetings or meetings with the offender (e.g. lack of attendance of the general medical doctor from the municipality in multiagency meetings -*ansvargrupper* in Norway- or the prison officer at planning meetings with offender). At an organisational level, the importance of engagement of the municipality, and occasion where this is absent, is particularly noted.

If we could get every partner then to come in here (the municipality) *and have*

meetings with us, with NAV, with the home municipality, the person themselves….. (Prison leader)

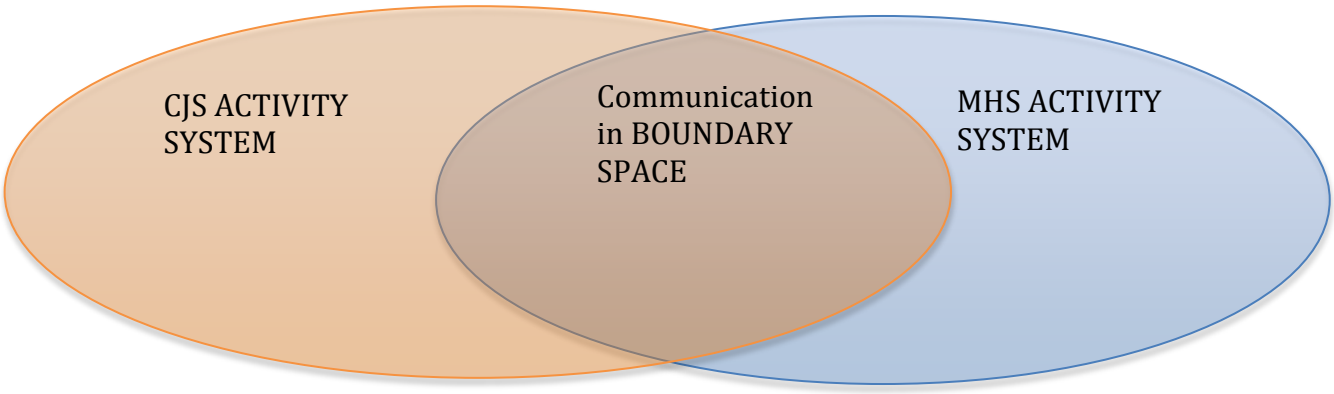

Figure 3: Boundary space where MHS and CS activity overlap

Activity within the boundary space

As the activity within each individual organization can be described in terms of a whole activity system, so too can the activity that takes place within the boundary space (Figure 4). The central activity described by participants within the boundary space is related to *communication* and *the sharing or allocation of responsibility.* Prison staff identify offenders' needs within their own system and then communicate these to the professional in another system who they deem responsible for addressing this need (e.g., prison officers communicating an offender's mental health issue to a visiting psychologist). Respondents describe how and why knowledge is communicated between actors when they are engaged in the process of assessing offenders' needs. They describe how they build social and professional networks or the offender that will provide the offender with resources and support. Professionals in the CS communicate information on the offender needs to professionals from the MHS, and receive in return information on possible course of action or availability of resource required to address these offender needs. The frequency, timeliness (early intervention or engagement with the offender), quality and reciprocity of communication are seen as important.

Tools mediating activity within boundary space

The MHS and CJS leaders describe how communication between professionals from different organisations working with the offender is mediated by a range of organizational structures. (see Table 1 for a summary of each of these tools). They

describe a clear *care pathway,* when dealing with offenders with acute mental illness, although it is not clear from the interviews the degree to which this pathway guiding the transition of the offender between prison and specialised services has been standardised. The care pathway is punctuated by a series of ad hoc *events/meetings* when and if offender needs arise and where prison staff phone, write or video link informally with professionals from other organisations. More formalised events are also described (e.g. including scheduled intra, inter organization meetings, *ansvargrupper,* service market squares and mediation boards). These formal and informal meetings mediate how communication and information flow between organisations takes place. This is also mediated by a range of assessment or coordination tools, including indivudalised plans, future/fremtids plans and shared electronic record systems.

Table 1: Tools mediating communication within the boundary space

Care pathway	They describe the use of secure cells in the first instance for the control and protection of the prisoner. These cells allow regular observations of behavioural change in the offender to be logged by trained police officers. A health concern must be reported either to the nurse or directly to the prison GP in a stated time period. If the condition is deemed beyond the expertise of the nurse or GP, and above a perceived threshold level of severity, the prison GP refers the offender to specialised mental health services. Specialised mental health assessment and treatment is then provided in the prison where psychologists and psychiatrists visit on a part time through an outreach service. Alternatively, if the latter professionals are unavailable, offenders are transported to the regional hospital or district psychiatric services. A secure ward at the regional hospital allows for hospitalisation, observation and treatment if required.
Ad hoc events/meetings	
Formalised events: ansvargrupper	These may include formal meetings such as routine staff meetings for prison staff or interorgansiational "*ansvargrupper*" and may include or exclude the offender. Ansvargrupper,for example, bring together a range of professionals from different organisations to meet regularly with the offender to establish and maintain long term sustainable support for those individuals with complex and longstanding conditions. This is seen as important in their release and reintegration back into society. These events may already be in place when the offender first makes contact with the criminal justice system but may be developed when the offender is serving their sentence also. Although it is not fully clear from interviews the prevalence of use of these groups in the offender population, the intention is to facilitate the offender's access to resources and cooperation between all participants including both professionals and the offender. Respondents indicated that they believed that not all offenders required this type of intervention, especially because these are viewed as resource intensive. Respondents' descriptions of the *ansvargrupper* suggests that these groups are loosely structured events, highly variable in the way these are run or

	the role/profession expected to initiate or lead the group. The involvement of the criminal justice system in the *ansvargrupper* is limited to the time period of the offender's sentence, which respondents suggest prevents professions in the criminal justice system taking a leadership role. The time limited period can be an advantage, however, as it enables the CS to take focused, more directed action when working with the offender during their limited period of involvement in this group. These discussions by leaders suggest that the community mediating communication activity is transient and variable, and the nature of communication likely to vary as the CS engage or withdraw.
Mediation boards	Respondents describe other formalised events facilitating communication with and between the offender and the range of services involved in their care. These include so called *grand meetings* lead by the Mediation Board. Following recent legislation (Hydle, 2015), mediation boards have the responsibility of convening interorganisational events to manage the community based sentences imposed on the young offenders. The offender, a range of professions, and the victim of the offence are brought together to work with young offenders and manage the execution of their sentence using principles of restorative justice. Respondents described these as more structured events, if compared to ansvargrupper, in that the initiation, leadership and membership is more clearly defined.
Service market squares	At a service, rather than professional level, offenders in prison have a legislated right to access a range of services (e.g. housing, employment) (Rehabilitation guarantee ref). These services are presented to them as a menu or *market square* of available services from which offenders can "shop" or select the service or services they require upon release. Respondents refer to the operationalisation of the concept of the *servistorget (service market*) as highly variable and may run as a scheduled activity which the offender can attend. Unlike ansvargrupper and mediation boards, interorganisational cooperation is not an explicit aim of these events. Health services are not currently included.
Interprofessional intra and	Respondents describe the importance of regular *intraorganisational meetings* in which information on the offender and related issues flows horizontally between staff and vertically between staff and organizational leadership. Unlike

interorgansiational professional meetings	grand meetings, ansvargrupper and servistorget, the offender does not participate in these activities. Respondents also describe the importance of regular i*nterorganisational meetings* at local and regional leadership levels and that serve to audit, project manage, problem solve and to discuss other strategic or systems level issues.
Coordination tool (e.g the individualized plan, Fremtidds plan)	The individualized plan (IP) is a coordination tool used by a range of services, with complex clients with multiple needs, to jointly map and coordinate support across the multiple services involved. In principle, respondents view this as valuable tool in the criminal justice system and offenders. The value lies in making services take responsibility for the support needs of the offender and respondents suggest the plan should be in place before sentencing takes place, should be in place as offenders prepare for release and could be used as a tool by Mediation boards in the execution of youth sentences. All respondents viewed the initiation of this plan as the responsibility of professionals in municipality services working outside of the prison. Leaders saw the IP as a tool, although seldom observed in the prison, environment, with potential to unify and reduce duplication in the plethora of other plans individual organisations already have in place. These other plans described include *the future plan* initiated by the prison to assist when mapping the offender's needs and in monitoring and evaluating subsequent actions to be taken by the offender during their prison sentence (e.g. education or rehab) in preparation for life on the outside. The tool is prepared in cooperation between prison social workers, nursing staff and potentially prison officers in partnership with the offender and may include plans to bring in external collaborators. The mapping dimension of the future plan is fed into by a recently implemented nationally held, electronic *needs assessment tool, BRIK*. In probation services, *social reports* fulfill a similar purpose to the future plan in the prison but are created before the agreement of sentence to support decision making on the nature of the sentence based on the description of the range of support systems currently in place that may dictate the eventual length and type of sentence handed down.

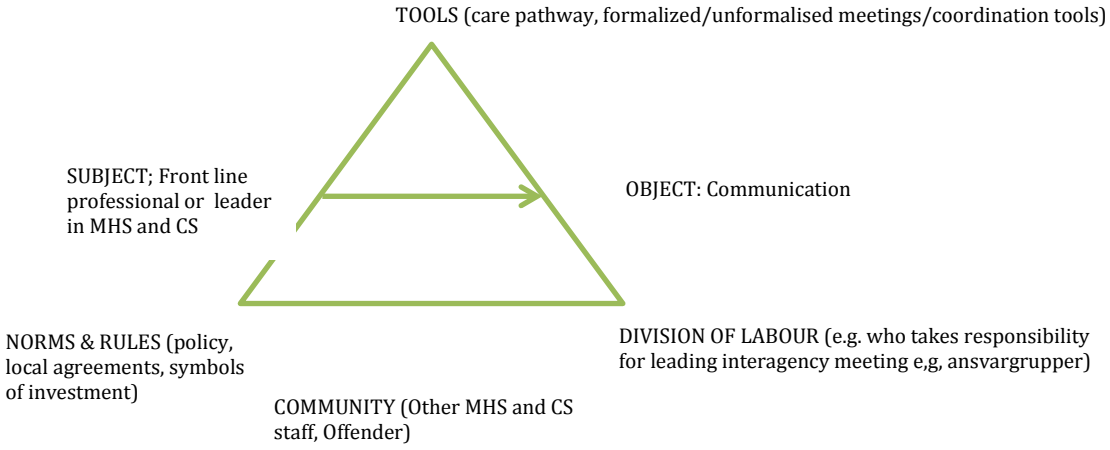

Figure 4: Tools mediating activity of communication within the activity system within the boundary space

Norms and Rules within the boundary space

Respondents, when reflecting on the *policy and interorganisational agreements*, describe some of the rules that are salient within the boundary space (see figure 4). They raise the existence of local agreements between organisations at regional, county, municipal levels and between local prisons, probation and a range of public and not for profit community based services. These agreements manage inter organisational working and the progress of these agreements are monitored regularly. Some of the agreements between specialised mental health services and criminal justice, directed at the delivery of specialist care for particular groups of offenders (e.g.sex offenders), were praised as working particularly well.

In Norway, recent legislation has been laid down to improve the coordination of health and social care services (Norwegian Ministry of Health Care services, 2010) Respondents, when discussing collaboration between MHS and CS, only referred to this higher level, if raised explicitly by the interviewer. Whilst one respondent suggested the coordination reform was being used as much as possible to improve collaborative practice, other respondents indicated there were areas of this reform that had not performed as expected, the lack of optimum integration of drugs and mental health services, two highly interdependent and prevalent conditions in the offender population, was described. One respondent suggested the reason might be because regionally the coordination reform, aiming to facilitate the integration of care between specialised health and commune services, had focused to date on somatic rather than mental health issues. Lack of services, resources and bed spaces in the

municipality also overrode the intention of the reform to facilitate the transitions of individuals from institutions (including prisons and hospitals) back into the community care.

Less formally, respondents describe symbols of collaboration, the format of a referral is one such an example. If the referral is done in writing (rather than oral referral over the phone for example), they describe this as being an overt sign of a symbol of the importance or urgency of the request. Similarly, financial and resource investment into a programme or service is seen to symbolize the engagement or commitment of the organisation to any collaborative project and working together. Similarly, new modern premises for low status offenders (e.g. sex offenders) is thought by respondents to signal the importance of the group and to encourage professionals to work with them. Professionals, by not answering emails or losing paperwork or organisations failing to engage in services or programmes symbolize a lack of willingness to collaborate. These constitute some of the unstated norms that govern the way communication between actors within the boundary space takes place.

Contradictions within the boundary space

A variety of *contradictions or tensions exist within and between activity systems.* There are two forms of contradiction identified in interviews. The first relates to the contradictions that occur within the boundary space activity systems itself and the second relates to those contradictions between the individual activity system and the boundary space activity system (Figure 5).

One tension, within the boundary space system, lies in the relations between the norm/rules dimension and the community of actors engaged in communication activity: actors hold *alternative professional interpretations/judgments of rules governing this boundary space.* Collaboration is impeded if one professional's judgment is not congruent with those of professionals in other organisations. This is illustrated first in relation to differences in professional judgment on need for referral. Prison GPs, for example must decide if the offender has reached a threshold level of mental illness to be referred to specialised mental health services. Specialised mental health services may believe this threshold has not been reached. Secondly, difference in views on confidentiality and information sharing may hinder communication activity: when information on an offender's mental health is transferred between MHS and CJS, alternative understandings and implementations

of confidentiality laws may impede collaboration. Health professionals need to exercise professional judgment about what information should be shared with the prison officer to enable them to do their job effectively whilst still protecting the offenders privacy and rights to confidentiality. Prison officers, however, describe instances whereby, despite signed consent being given by the offender for the MHS to share information, information on an assessment is not forthcoming making it difficult for the prison to manage the care and behaviour of the offender in an appropriate way. The above is a failure in horizontal communication. Communication may also fail vertically, when directives agreed by inter-organisational meetings, at a systems or leadership level, may not filter vertically down to the frontline professional.

A second contradiction described by leaders related to the norms and rules dimension of the boundary space activity system, specifically the *utility of local agreements.* Respondents are aware of the limitations of local agreements and the balance to be achieved between the implementation of these and offender centric care. There was a stated preference for working at the level of the offender and addressing individual needs rather than more system level approaches presented by the agreement. For example, local agreements may be set in place for municipal services to receive a set number of offenders, over a stipulated time period but the number of offenders and date of accessing the service upon release varies with offender compliance and eventual release date, both of which can be unpredictable. This compromises the utility of the agreement in discussion both of the mediating tools and norms and rules described, respondents show an awareness of the tension between a need for regulation and standardisation of collaborative practices versus offender centred care. Standardisation on the one hand ensures the reliability and equity with which services are coordinated and integrated continuous care experienced. One the other hand, the complexity and uniqueness of each offender means providers need to map and maintain offender networks tailored to each individual.

A final contradiction within the boundary space is the lack of use of the IP as a tool with which to mediate communication. As mentioned earlier, respondents believe there to be little implementation of this tool in the criminal justice context and respondents fall back on their silo specific tools, when no IP is available. They speculate on why the IP is not being used: it may be difficult to implement, especially as prisoners move around during their sentence; plans are resource intensive to generate and/or offenders may not want one in the first place. The IP appears to be

seen as valuable in principle as collaborative tool and as a consolidation of other plans but implementation is problematic.

Contradictions preventing entry into Boundary Space

The above contradictions occur within the boundary space activity system. Other contradictions occur when there is a tension between each individual activity system and the activity system represented in the boundary space; a tension that prevents entry into the boundary space to begin with. For example, there is no reference in the interviews to any shared resources between devoted to collaborative activity. Resources are drawn therefore from individual activity systems. A lack of resource in the individual activity system restricts collaborative activity in the boundary space. In the MHS/CS context, limited human resources constrains the capacity of organisations to enter into the boundary space and engage in the collaborative tasks of mapping and addressing offenders' needs. Respondents describe how in prisons only the most needy may receive a full needs assessment, for example, because of the limited number of social work staff available to perform this role. Prison officers may be engaged to perform this role as one resolution to this tension. Similarly limited capacity in the police force may restrict the number of offenders in custody that can be transported from prison to specialised mental health services in the regional hospital or the municipality may not be able to release staff to come to the prison to address the needs of a particular individual. CS respondents also suggest that a lack of engagement by other services maybe as a result of other services' desire for temporary respite from the offender during the period of their sentence. In addition to human resource, limited housing places in the municipality, limited beds in community services, the need to make savings in current times of austerity, no service at all in the home area of the offender and the fact that offenders needs are complex, and addressing their needs being cost intensive, means that opportunities for collaboration are lost.

Similarly, *logistics constrain collaborative opportunities* between collaborating professionals. In this case contradictions occur between the norms and rules of separate systems**.** In incompatible working schedules of professions in each organisation and the geographical distances between the prison on the one hand and community and specialised services on the other, means that building the network of collaborators around the offender is challenging. It is especially so when, for reasons of security, the services are encouraged to come to the prison rather than the offender being transported, at expense, out of the prison.

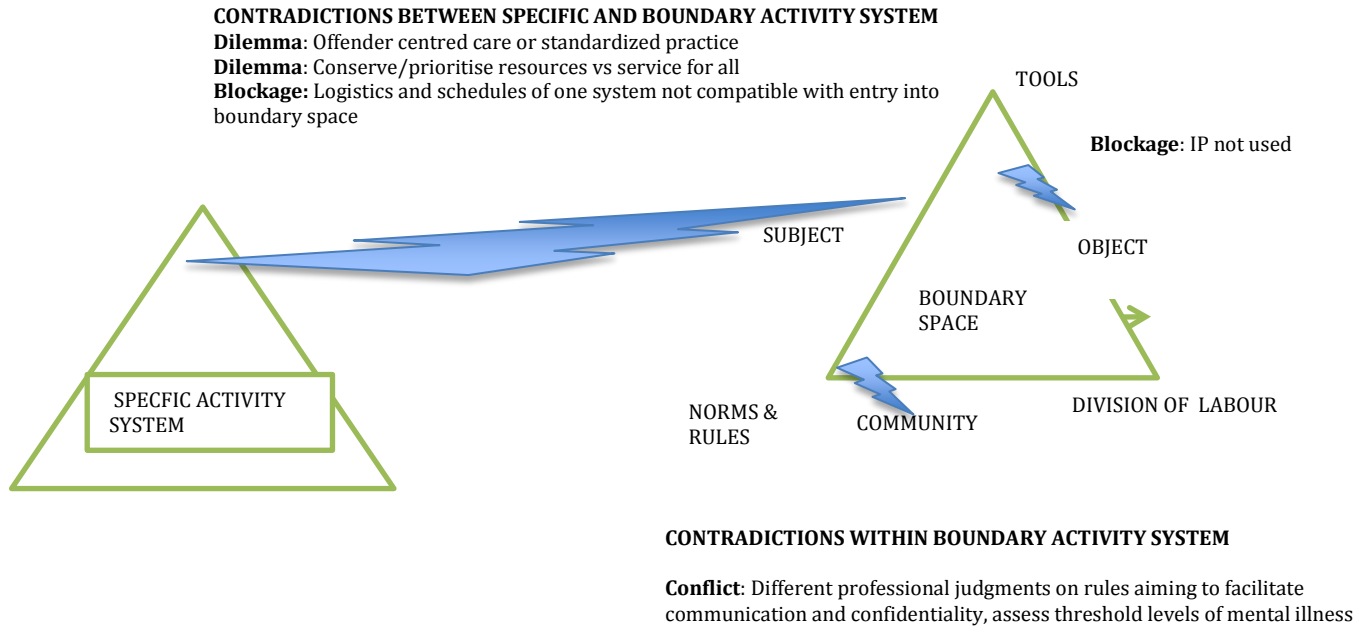

Figure 5: Tensions within the boundary space and when entering boundary space

DISCUSSION

Leaders in the CS and MHS when interviewed about their perceptions of collaboration between these systems, highlight the rehabilitation and preparation of mentally ill offenders release back into society as areas where MHS and CS professionals most often collaborate. Three main activity systems overlap during this period, namely the activity systems of the specialised mental health services, the correctional/prison services and of the offender themselves.

As separate activity systems, the MHS and CS work on separate activities related to identifying and prioritising offenders' needs, mapping and mobilising resources or providing treatment within the confines of their own system. These activities however must be coordinated with the activities of the other two systems and it is around the coordination of these activities that interprofessional and interorganisational collaboration is played out. Professionals from the MHS (such as psychologists and psychiatrists from specialised mental health services) enter a shared boundary space with professionals from the CS (prison officers, prison nurses, prison doctors). They enter this space because of shared values and challenges related to offender rehabilitation and when they recognize that their being able to support the offender relies on the input of another service.

The boundary space in itself forms an activity system, the main activity of focus being interagency and interprofessional communication of information related to the mental illness of the offender and its management. This is in line with Thomson (1967) who believed that reciprocally interdependent activity needs to be coordinated through constant information sharing and mutual adjustments. Knowledge communicated is often propositional in nature (i.e. information being communicated verbally or in writing) (Heron and Reason, 2008). However, they describe communication that is symbolic or presentational in nature: the importance of a new pleasant building for the treatment of sex offenders in prison for example. This signals the importance of working with this group. Importance of information is also represented when written rather than communicated by phone and there is implicit meaning given to prison officers failing to reply to emails. These constitute some of the unstated norms that govern the way communication between actors within the boundary space takes place.

Further, with the boundary space is visualized as a separate activity system, the

communication activity can be described as mediated by a range of tools or integration devices that are aimed at facilitating interagency communication and include service level agreements, coordination tools such as the joint individual care plans, and standardised interagency meetings between inter-professional groups and patients, to deal with complex, long term conditions (e.g. *Ansvargruppe* in Norway(Saebjørnsen & Willumsen, 2015); Multiagency). Similar tools are used in other national contexts (e,g, Multiagency public protection arrangements-MAPPA in UK)(Ministry of Justice, 2012). These structures are boundary objects (Star, 1998) that facilitate communication in the boundary space, with the ultimate goal of coordinating system specific activities.

The study suggests that these generic integration tools may not be working as effectively as desired as contradictions within and between MHS and CS systems remain. The interview analysis suggested that there are currently a range of contradictions within and outside of the boundary space that require resolution if collaboration between the MHS and CS are to be improved in this Norwegian context. Engeström & Sannino (2011) describe linguistic cues and discursive manifestation of contradictions, paying particular attention to conflict, dilemmas and double binds as visible observation of these contradictions. Although a full exploration of contradictions of the linguistic, and dialectic manifestations of contradictions, had not been the focus of this study, we see evidence of dilemmas and conflicts specifically in these discussions of collaborations between the MHS and CS. Engeström & Sannino (2011) describe dilemmas as "Expression or exchange of incompatible evaluations", associated with linguistic cues such as "on the one hand this, but on the other hand that". Conflicts are associated with words such as *no* and are described as examples of argument and criticisms of the actions of other, that may be resolved by compromise.

In terms of conflicts within the boundary space, respondents from the MHS and CS in this Norwegian sample were not open to providing any stories of critical conflicts where severe personal and emotive impact of conflict could be described. This was even when respondents were invited expressly to discuss where collaborations had worked well and where these hadn't. Descriptions of conflict remained at an impersonal level, describing alternative professional judgments related to offenders being admitted to hospital services or the negotiation and interpretation of confidentiality laws by MHS and CS professionals respectively. As Engeström & Sannino, (2011) suggest in studies of the manifestation of contradictions in

organisations in Finland, there may be a cultural element at play that precludes professionals from being emotive or blaming colleagues explicitly.

In terms of dilemmas, respondents describe needing to standardize care pathways for offenders as they pass between systems through, for example, standard coordination tools and service level agreements, on the one hand but needing to balance this against the unique nature of each offender's challenges and the need to provide a bespoke service to them. Similarly, professionals want to offer a service to all but limited resources means that leaders speculate that professionals, in order to conserve resource, prioritise non –offender populations or deliver services to offenders who present with only the most serious conditions. Finally, security requirements means health professionals are encouraged to come to the prison to deliver their services but lack of time resource and distance to the prison makes this less feasible.

Our respondents did not discuss double binds (situations were alternative choices are equally unpalatable).

Some of the other challenges described by respondents appeared less about contradictions within the system and more about blockages, although there may be dilemmas, conflicts or double binds that underpin these blockages but these weren't uncovered in these discussions and require further exploration. The lack of implementation of coordination tools such as the IP, lack of vertical communication from leaders to front line professionals and logistical compatibility in terms of scheduling, are examples of this. The ineffectiveness of coordination tools as integration tool is reported more generally outside of the MHS/CS context. In Norway, for example, individualised care plans were only implemented in 0,5% of the population(Bjerkan, Richter, & Grimsmo, 2011) when the intended target was 3%, for example.

The difficulty in getting some of the integration devices described above to work in practice, can be explained by the concept of street-level bureaucracy(Lipsky, 1980): Front line professionals in public services function with high levels of discretion and autonomy. Policies imposed upon them "top-down" often do not correspond to the specific client or work situation they encounter. In response, they develop coping mechanisms whereby they have to adapt or ignore the policy structures imposed upon them. Failure to convene or attend interagency meetings between the MHS and

CS, professionals claiming a lack of resource, is typical of this. This is often not a conscious, intentional activity (sometimes referred to as bricolage - Fuglsang, 2010) but can lead to unintended consequences.

A lack of attendance or effectiveness of interagency meetings frequently occurs because there is little guidance on who should convene and lead these and the processes that should take place within them. When no explicit model of collaboration is applied, participants rely on tacit knowledge of how they should work with other professionals. It means it is difficult for them then to reflect and improve on how to make these meetings work more effectively. As in other interprofessional interactions (Dickinson & Carpenter, 2009) *contact* between the MH and CS professionals alone, the current strategy for inter-organisational collaboration, and relying on tacit knowledge on how to work together, is unlikely to be sufficient for communication, innovation and effective problem solving to occur. In fact it can be detrimental to inter-organisational relationships (Bridges & Tomkowiak, 2010).

The overlap of the MHS and CS and offenders' activity systems is a particularly complex adaptive environment where many elements interact with each other in often non-linear and unpredictable ways. As such, collaborative working is defined as a "wicked problem" in service planning (Rittel & Webber, 1973). This means the exact problem is often difficult to define; it exists within open systems being influenced by a multitude of interacting influences; multiple solutions may be available but these are each difficult to predict, test or disprove and will vary in effectiveness depending on the context and stakeholder involved. As such any solution aimed at improving reoffending rates, rehabilitation and interagency working will resist attempts to develop standardised care pathways, interagency meetings or service level agreements between organisations that promote uniform, one size fits all coordination of care across agencies

Way ahead

The challenge now remains for the conflicts, dillemas and blockages to collaboration between MHS and CJS systems, and as raised by leaders in the current study, to be resolved. The Change Laboratory Model (CLM) offers an alternative to these standardised tools of integration/collaboration. The central tenet of the laboratory is the creation of a 3 X 3 matrix of viewpoints for participants to reflect on their working practices. In the vertical plane, participants explore their working practice in the past, present and future. In the horizontal plane, they do this at three levels of abstraction.

At the most concrete, they work with an object that mirrors their working practice and illustrates the problems and disturbances of their work (e.g., Video footage of work practice, service user feedback), collected before hand by researchers in ethnographic studies of practice, are used as this mirror. At the other end of the abstraction spectrum, participants theoretical models based on activity system theory (CHAT) that helps them conceptualizes their work activity and make sense theoretically of the built-in contradictions generating the troubles and disturbances depicted in the mirror. [18,19] The vertical and horizontal planes interact to create a third and middle plane representing the ideas that surface during discussions between participants as solutions/innovations to the contradictions they have uncovered. They then explore these in a cyclical and iterative manner with regard to their potential capabilities in transforming current working practices. (Engestom, 2007; Virkkunen & Shelley Newnham, 2013)

The Change Laboratory Model (CLM) is superior to the status quo in current MHS/CS collaboration, because in current interagency interactions, the collaborative process is only understood tacitly. The CLM however codifies this tacit knowledge. It focuses on how information is shared, the manner in which knowledge can be understood across disciplinary boundaries and combined in such a way that new concepts are cocreated. CLMs also recognize that innovation happens at the boundaries between disciplines and that working across boundaries is a key ingredient of competitive advantage.(Carlile, 2004) In current collaborative models, practice problems tend to be identified by leaders. In CLMs however, problems are identified by front-line professionals, and the facilitator helps them reconceptualise these. The change lab is designed, with the use of the mirror and theory, to unpick what actually is the problem from the mouths of people that are actually performing these collaborative activities, and in their particular work place environment. Similarly, currently, solutions to collaborative practice challenges are management or researcher driven, and adaptations of these by frontline professionals are often unintentional. The CLM however allows bottom up innovations to be developed. This means professionals are encouraged to develop their own solutions to the challenges they face. The CLM makes the bricolage process an intentional one, allowing professionals to consciously adapt policy in a way that is relevant and effective in their local environment whilst remaining politically accountable for their practice.

Current collaborative tools such as care pathways, service level agreements and coordination tools are attempts to standardise collaborative practice but each CLM is

unique. This model of interagency cooperation allows front line workers and offenders to work together to identify and resolve issues they have identified as problematic rather than impose top down standardised solutions to what management perceive to be problematic, something already shown to be ineffective.

The validation of these change laboratories in the MHS/CJS is the remit of the wider study from which this paper is drawn, as a means of addressing the potential contradictions have been identified in the collaborative activity between the MHS and CS.

Limitations

A main limitation of the study is that the utility of CHAT only became obvious after the collection of the data and did not inform the design of the research questions, the interview schedule or analytical framework. We would recommend in future studies that the boundary space between the MHS and CS is explored in further depth using the model presented in Figures 2-5 as an overarching framework and that the dimensions of the boundary space activity system become a specific area of focus.

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Conclusions

In this paper, the problem or boundary space between the MHS and CS services in a Norwegian context has been described from the perspective of leaders and in terms of an activity system within its own right. Using this CHAT lens, key contradictions and blockages within and surrounding the boundary spaces are identified and it now remains to complement this perspective by including the voice of front line professionals and most importantly the offender themselves in future explorations of this boundary space as well as validate and test the feasibility of change laboratory models as an alternative tool with which to mange interagency collaboration between the mental health services and prison services, to better address offender rehabilitation.

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