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Interprofessional Collaboration Concerning Offenders in Transition Between Mental Health and Criminal Justice Services. PINCOM Used as a Framework for HCR-20^{V3} Assessment

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Introduction

Service demands, when offenders make the transition from prison back into society, are complex and challenging. Offenders often need support and help from a range of professionals representing different services (WHO, 2010), as offenders often have multiple problems, including mental health problems. In Norway, for example, studies clearly describe a higher incidence of mental disorders among inmates than among the general population (Cramer, 2014). Among offenders, only 8% have no mental illness, whereas the rest have extensive diagnoses (personality

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S. Hean et al. (eds.), *Improving Interagency Collaboration, Innovation and Learning in Criminal Justice Systems*,
https://doi.org/10.1007/978-3-030-70661-6_10

disorders, 73%; drug abuse, 51.3%; anxiety, 42%; alcohol abuse, 28.7%; mood disorders, 23%; ADHD, 18%; risk of suicide, 12%; and psychosis, 3.3%) (Cramer, 2014). This calls for the development of new interagency collaboration arrangements (Hean et al., 2015). A major challenge is that services, prison and mental health services for instance, are often fragmented with different responsibilities, laws and regulations.

The main scope of this chapter is to introduce and discuss the feasibility of two tools that may enhance collaboration among service providers. First, we describe the HCR-20^{V3} (Douglas et al., 2013) and suggest how parts of it can be jointly used as a tool for concrete collaboration in the practice field. Next, we present the PINCOM tool, containing a conceptual model (PINCOM) and a research methodology (PINCOM-Q) (Ødegård, 2006). This tool was developed to (a) assist in organising collaboration processes in multilevel interprofessional challenges and (b) increase knowledge about collaboration through a new research methodology (PINCOM-Q). Finally, we present and discuss some relevant issues for professionals engaged in collaboration processes involving offenders' trajectories from prison back into society. It is suggested that the PINCOM can be used within a larger social innovation framework and as a reflective tool during or after structured professional assessment, such as the HCR-20^{V3}.

The Need for Interprofessional Collaboration

Authorities and health promotion organisations, such as WHO, have promoted integration of health and prison services for decades (Wolff, 2002). Still, we do not have much research that illuminates collaboration processes in the trajectory from prison into society. According to Hean et al. (2017a) and a literature review conducted by Brooker et al. (2009), collaboration between the criminal justice system and the mental health field is underinvestigated.

Interprofessional collaboration is often described as a complex phenomenon that needs conceptual models that capture different aspects of the collaboration processes (Reeves et al., 2010). This is evident as there are many definitions of collaboration and related concepts—all of which attempt to capture the complexity of professional interaction

(Barr et al., 2005; Leathard, 2003). When professionals from different services and/or "systems" collaborate, it is not a given that they will have the same conception of what "to do" when collaborating and what they should collaborate about. For example, an offender leaving prison will most probably need several services to be able to cope with life outside the prison. Central needs will often be housing, work, a network, and medical and social services. Professionals working in the prison and professionals working in the community and in special services will need to meet and discuss with the prisoner a plan for life outside the prison. In a qualitative study, Hean et al. (2017a) found that leaders in the field were especially concerned about the distribution of responsibility for the offender across systems. If leaders (and professionals in different systems) only try to demarcate their own responsibility rather than look for joint solutions, collaboration may fail before it begins. In one of the few studies from the Norwegian context, Hean et al. (2017b) explored prison officers' perceptions of collaboration between different systems and professions. It was no surprise that findings showed that prison officers significantly perceived less collaboration with mental health specialists than with nurses and social workers in the prison. The same respondents requested "much greater contact with mental health specialists when dealing with the mentally ill offender" (Hean et al., 2017b, p. 91). In sum, there are clear indications of the need for the development of new approaches to collaboration in the trajectory from prison into society.

However, collaboration is not a goal in itself; actors need to collaborate about something that is useful and has positive and constructive outcomes for the offender. As presented in the beginning of this chapter, we will introduce and discuss the feasibility of two tools that may enhance such collaboration. The last few decades have seen the development of numerous instruments for risk assessment of violence. The HCR-20^{V3} (Douglas et al., 2013, 2014) is the most widely used instrument in risk assessment of violence worldwide. Douglas et al. (2013) claim that professionals should collaborate across disciplines when using the HCR-20^{V3}. Assessment of risk of violence must take into consideration that violence is a context-dependent phenomenon. Thus, when different persons from different services collaborate on using the HCR-20^{V3}, a more nuanced risk assessment results due to the sharing of

knowledge. Still, in the practice of collaboration, it is often taken for granted that professionals know how to collaborate. This is not necessarily true. As indicated above, it is not at all clear what professionals (prison officers and mental health professionals) perceive collaboration to be. To arrive at a common understanding of collaboration, the professionals involved need to explore each other's individual understanding. Doing so could even produce new insights about the phenomenon at hand (for example, risk management issues), but also contribute to a broader and deeper understanding of what collaboration is about. New insights could even be understood as an epistemological change. Collaboration among professionals has the potential of moving from simple linear to contextual and reflexive communication (Ødegård & Bjørkly, 2012). As Hoffman (1985) described, the emphasis shifts from a concern with the etiology of a problem to a concern with the meanings that are attached to it. This shift has been described as a principal difference between the understanding of change in first- and second-order perspectives, from a perception of reality as absolute to one that is individually and differentially perceived. In this chapter, we present two tools through which individual perceptions may be aligned during collaboration: the first is the HCR-20^{V3} as a tool for generating contextual and shared understanding of violence risk. The second is PINCOM-Q as a method for identification and development of contextual and shared understanding of interdisciplinary collaboration between professionals involved in the trajectory between prison and society.

The HCR-20^{v3}

As noted above, the HCR-20^{V3} (Douglas et al., 2013) is the most commonly used structured professional judgement tool for violence risk assessment. It comprises 10 historical risk factors, five dynamic risk factors, and a risk management scale with five items about adjustment to future risk-related circumstances. A conventional use of the tool means that personnel in charge of a patient or an inmate at the initial phase of transfer do the assessment and present the results to personnel in the services that will engage with the inmate later on. This sequential,

one-by-one approach runs the risk of supporting separate positioning, interprofessional misinterpretations, disagreements, and complications in the transition process.

The first version of the HCR-20^{V3} appeared in 1995, and it belongs to the Structured Professional Judgement (SPJ) tradition (Singh et al., 2016). This approach uses a structured practice based on the "state of the discipline" concerning scientific knowledge and professional practice. *Structured* means that risk assessment is evidence-based and that the tool is a stepwise guideline on how to assess the 20 items. However, the coding of the items is only two (Steps 2 and 3) out of the following seven steps:

1. Gather information.
2. Determine presence of risk factors.
3. Assess the relevance of the risk factors.
4. Develop a violence risk formulation.
5. Develop risk scenarios of violence.
6. Develop risk management strategies.
7. Final opinions and conclusion.

The first step is similar to the starting point for most approaches in clinical assessment. Step 2 is to identify which risk factors are or have been associated with violence for the individual in question. This person may have a history of problems with substance abuse (Item H5) and major mental disorder (H6), recent problems with insight (C1), and symptoms of a major mental disorder (C3) that precipitated the violence that sent him to prison. His treatment or supervision response has been negative (R4) after previous transitions from prison to mandatory community treatment. The assessment of how relevant (Step 3) each item is for current and future violence provides important information for developing risk formulation (Step 4), risk scenarios (Step 5), and risk management strategies (Step 6). The risk formulation is intended to explain *why* violence may reoccur: For example, in cases of decompensation (a decline into ideas of delusional persecution), the individual´s emotional distress increases to a level that he cannot cope with, and the risk of paranoid violence "in self-defence" becomes high. The motivation

for turning to violence is a means of "acting out" that generates a transient relief and diversion from intolerable internal psychosis-triggered pain. This is termed *negative reinforcement* in behaviour therapy. Based on this interpretation, two different types of risk scenarios are created. One *best-case scenario* may be that he is transferred to mandatory treatment in a community residence with 24/7 follow-up by mental health personnel (R1. Professional Services and Plans). He is put on forced medication and he resumes the work he had before the violent crime. Personnel are trained to identify and intervene if certain warning signs of psychotic decompensation appear (R5. Stress and Coping). A *worst-case scenario* would be that he is moved to different housing and a new workplace where he does not want to stay. His only follow-up by mental health personnel is one session per week in an outpatient clinic (R1. Professional Services and Plans). He ceases medication and starts up again with substance abuse (H5). Even if these examples are somewhat exaggerated for clarity, they illustrate the significance of context (R2. Living Situation) and risk management strategies in theassessment of violence risk for prevention of violence recidivism.

Risk Assessment with the HCR-20^{V3}: The Paramount Role of Context Factors

We will illustrate and discuss now the potential meeting points for collaboration that lie in interdisciplinary discussions and knowledge sharing of information related to relevance, risk formulation (why the violence may occur), risk scenario, and risk management strategies. To meet the criteria for being a *relevant* risk factor, a factor must be (1) functionally related to past violence, (2) likely to influence the person's decision to act in a violent manner in the future, (3) plausible to impair the individual's capacity to employ non-violent problem-solving, and (4) of contextual nature. The latter contextual factors are important in order to understand *why* and to what extent a person will be violent. For example, a *risk formulation,* for an individual acting on violent persecutory delusions as the core risk factor, will be different in a stable and predictable context if compared to when the person is experiencing unstable living conditions. One difference is that in a secure and calm milieu, a person

will be helped in response to her emotional distress instead of having her anxiety ignored until it turns into the last resort—violence.

Risk scenarios depict operationalised risk situations or contexts for violence. The difference between a worst-case scenario and a best-case scenario may in fact lie in the different contexts the person finds themselves. There is a huge difference between the scenario of a drug-addict being transitioned from prison to the drug abuse milieu he came from, compared to his entering a structured treatment programme for drug abusers. A context-free risk assessment is therefore not meaningful, and, since professionals from different services are making observations in these different contexts, sharing these observations and interprofessional cooperation between services may inform the assessment of violence risk in an individual case.

Similarly, risk management strategies will be different depending on the context into which these are introduced. We must also consider how the implementation of these strategies in turn changes the context. There are three important steps that must be followed in this process: first, a structured risk assessment of violence that provides information about a person's risk situations is made; second, the likelihood of how often an individual may be exposed to these situations is assessed. Finally, the proper risk management strategy is developed and implemented.[1] If prison and mental health services acknowledge the impact of contextual factors on violence risk, then their sharing of observations and knowledge becomes easier and more valuable in each case. Prison officers are experts on the here-and-now risk in the forensic context and, based on risk scenarios, may suggest risk management strategies to the mental health services. The latter service has expertise on the treatment of psychosis. They also know what kind of living context and follow-up procedure they can offer once the prisoner is released. This allows for a collaborative rather than competing communication whereby the expertise of each is acknowledged. Still, this is not enough to guarantee success.

To help parties grasp the possibility of positive interprofessional collaboration, a bird's eye view of the collaboration landscape needs to be

[1] User involvement is, of course, also a must to succeed in this process. However, since interprofessional collaboration is our main focus here, we do not elaborate more on the role of users in the transfer between services.

developed. In cases where individuals are making a transition from one service to another, a common perspective and understanding of this process needs to be developed. This is where other tools such as the PINCOM fits in.

The Perception of Interprofessional Collaboration Model (Pincom)

The Development of PINCOM and PINCOM-Q

Kelly (1955) claimed that "a person's processes are psychologically channelized by the ways in which he anticipates events" (p. 46). Consequently, professionals from different services will, when engaged in collaboration processes, have their own (idiosyncratic) perceptions of what is going on and how the process should come about. In one study, Ødegård (2005) found indications that perceptions of interprofessional collaboration could be understood at an individual, a group, and an organisational level. The Perception of Interprofessional Collaboration Model (PINCOM) describes 12 facets that make up these perceptions of the collaboration process at these three levels.

PINCOM was developed through a combination of a literature search, theoretical influences from organisational and social psychology, and clinical experience. The result is the following conceptual model—PINCOM (Ødegard, 2006).

Each of the 12 constructs included in the PINCOM was operationalised by four items, producing a 48-item questionnaire, PINCOM-Q.[2]

[2] The PINCOM-Q may be accessed on the webpage NEXUS, which is a national center in USA: "The National Center for Interprofessional Practice and Education was formed in October 2012 through a cooperative agreement with the United States Department of Health and Human Services, Health Resources and Services Administration". Its mission: "The National Center offers and supports evaluation, research, data and evidence that ignites the field of interprofessional practice and education and leads to better care, added value and healthier communities" (https://nexusipe.org). https://nexusipe.org/informing/resource-center/pincom-q-perception-interprofessional-collaboration-model-questionnaire.

PINCOM as an Analytical Tool in the Collaboration Process

In addition to being a quantitative research instrument, the conceptual framework of the PINCOM model may be used in collaboration processes, for example, as starting points for conversations about the meaning of interprofessional collaboration. How this may unfold is depicted in the following brief case illustration about Peter (age 23) who is leaving prison:

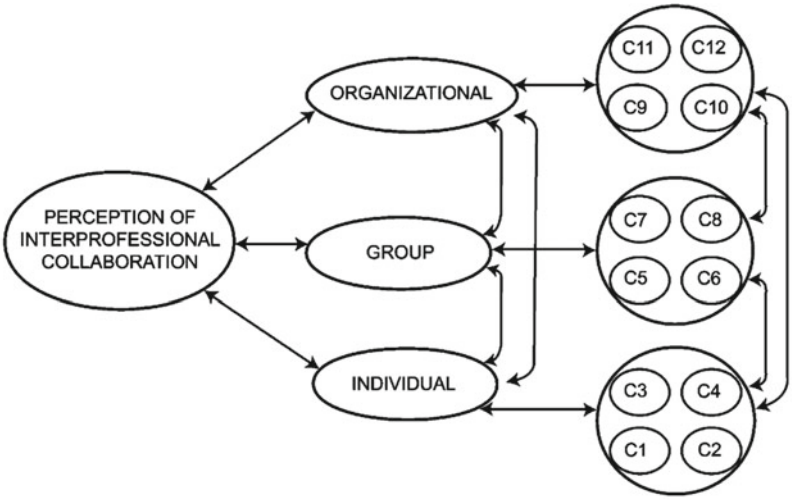
> *Peter has served his third sentence in four years in a Norwegian prison. He has been convicted for different drug-related crimes, such as the use of drugs (amphetamine), dealing drugs, and violence towards people in the "community" of drug abusers. Peter grew up in a foster home because his mother could not cope with his behaviour when he started using drugs at the age of thirteen. Presently Peter has decided to try to live a life without drugs, and, upon his release, a meeting has been arranged where the main purpose is the use of the HCR-20^{V3} assessment. Several professionals, from the criminal justice system and health and social services, participate in the meeting together with Peter and his older brother, who works as a carpenter.*

The Norwegian Directorate of Health recommends that violence risk assessments be carried out in an interdisciplinary collaboration context where there is the necessary expertise. Interdisciplinary collaboration in this regard means that different occupational groups of health professionals with expertise in the topic of violence risk work together to do the HCR-20^{V3} assessment. The final assessment should be done by a physician or psychologist who has expertise in risk assessment of violence (Helsedirektoratet, 2020).

How would a meeting around the HCR-20^{V3} assessment unfold in the case illustrated above? Most likely, the discussions would deal with the following topics: resources, adaptation, and feasibility. High-quality collaboration processes are a prerequisite for goal attainment in interdisciplinary work across services (Hean et al., 2017a). As we mentioned earlier in this chapter, prison officers are experts within the forensic

context, whereas professionals from mental health services have expertise on treatment of psychosis. Although acknowledging each other's expertise is a prerequisite, this is not enough to guarantee success as *collaboration* is a fuzzy concept (Biggs, 1997). This means that each professional present in the meeting may perceive the process around HCR-20^{V3} differently, including how each understands Peter's problems and strengths, as in, for example, Steps 2–4 in the HCR-20 assessment.

PINCOM Individual level dimensions C1–C4: With regard to collaboration while working within the different steps in the HCR-20^{V3} assessment, it is suggested in PINCOM that professionals will tend to construct different aspects of collaboration during the HCR-20^{V3}assessment in their own way. Some professionals will tend to focus basically on individual aspects of the collaboration process (see Fig. 10.1), such as motivation (C1), role expectancy (C2), personal style (C3), and



C1 = motivation, C2 = role expectancy, C3 = personality style, C4 = professional power, C5 = group leadership, C6 = coping, C7 = communication, C8 = social support, C9 = organizational culture, C10 = organizational goal, C11 = organizational domain and C12 = organizational environment

Fig. 10.1 Perception of Interprofessional Collaboration Model (PINCOM) (Ødegård, 2006)

professional power (C4), whereas others tend to focus on group or organisational aspects. Are the professionals present engaged (C1) in helping Peter in his rehabilitation process, for example, showing interest in taking responsibility during his return to society? Or do they see collaboration with other services as unnecessary or futile hereby lacking the motivation to engage? Furthermore, what role expectations (C2) do the participants have for each other while collaborating? For example, what do prison staff expect from mental health professionals, and vice versa? Next, some professionals with expertise in risk management strategies may want to focus on risk specifically in the meeting. If no special attention is given to this professional's individual expertise in the meeting, some participants may feel that others are exerting their professional power (C4) over them. This would most likely disrupt communication in the meeting. It is important to acknowledge each other's competence regarding information and knowledge concerning Peter in both the present and future contexts. Finally, professionals are all different, and some may have a personality style (C3)—for example being very extroverted and talkative. Such a style, of course, might affect interactions among participants, limiting sound dialogue during the HCR-20^{V3} assessment. As a result important information might not come to light during discussions if some of the participants do not describe their perceptions of Peter and his challenges due to tensions among the meeting participants.

PINCOM Group Dimensions C5–C8: Collaboration processes are deeply dependent on the quality of the interaction between the participants. Before Peter's transfer back into the community from prison, there is a need to discuss and plan the collaboration process. A good way to start is to establish a joint transfer group comprising professionals from the prison service and community mental health care. Interactions and interrelations in this group will depend on individual characteristics, as suggested above, but, as well, there will be specific aspects of how groups or teams function that are equally important. PINCOM has included some elements that are considered especially central during collaboration processes: leadership (C5), coping (C6), communication (C7), and social support (C8).

It is difficult to obtain a well-functioning HCR-20^{V3} assessment without some kind of leadership (C5). Who leads during the assessment

and what kind of leadership style contributes best to a valid HCR-20^{V3} assessment? The dynamics between a moderator and the rest of the group are very important. The moderator should pay close attention to how different contexts are considered during HCR-20^{V3} assessment and by whom. If important information about Peter's behaviour in certain contexts is supressed, it might have potentially serious consequences. The moderator, therefore, has an important role in planning the collaboration process before transfer starts. Second, groups that function well tend to "experience" or learn coping strategies (C6) and thereby have a greater likelihood of performing even better the next time they collaborate. Communication (C7) is a broad and complex phenomenon and trying to develop good communication processes is complex. Therefore, participants in interprofessional groups, and especially the moderator of the group meeting, should strive hard to accomplish sound communication processes. It is not a given that the professionals in Peter's meeting are able to communicate clearly and mutually about his risk behaviour or other themes in his life. So how should communication unfold to gain the best possible outcome for the HCR-20^{V3} assessment in an interdisciplinary context? This, we believe, is a question that participants in a given meeting probably need to discuss. Finally, a fourth aspect at the group level is social support (C8). To what degree will professionals engaged in interdisciplinary meetings support each other, while working together very often on highly complex cases? For example, are they able to support each other, even though they sometimes disagree or differ on certain aspects during the HCR-20^{V3} assessment?

PINCOM Organisational level Dimensions C9–C12: The third level in PINCOM focuses on organisational aspects of collaboration. To a certain degree, participants will perceive organisational aspects involved in interprofessional collaboration processes differently. For example, organisational cultures (C9) may facilitate or hamper collaboration processes. Some organisations may value collaboration, as this may produce good outcomes for service users and service providers. However, other organisational cultures may rely strongly on what professional "domain" the organisation covers. In the HCR-20^{V3} assessment process concerning Peter, some professionals may become passive if they believe (or argue) that the assessment lies outside their organisational domain

(C11). Likewise, some may claim that the organisation they represent have aims (C10) that do not correspond to issues raised in this particular meeting. Finally, other aspects, such as the organisational environment (C12) may influence collaboration processes between professionals. In the case of Peter, this could be professionals in the justice system, such as lawyers, or health and social services, or professionals from the Norwegian NAV (Norwegian Labour and Welfare Organisation) not being represented in the meeting. Furthermore, the community personnel may have known Peter from three years back before he went to prison and need an update about his progress over his time in prison and his current circumstances. They also have expertise in what kind of follow-up they and other services can provide in terms of living conditions, work options, etc.

Discussion

Risk assessment with the HCR-20^{V3}: An interface for interprofessional collaboration?

As pointed out above, the common denominator for risk relevance, formulation, scenario, and management is the significant role and impact of contextual factors. Professionals from different services have observed a person in different contexts, and this may add synergy to a more multifaceted contextual understanding of an individual and his or her violent behaviour. The structure and predictability when serving time in prison is very different from the open follow-up when individuals are back in the community. The main question is what kind of knowledge and preventive measures are generated by comparing observations of and interactions with a person in different contexts? The answer depends on who participates in the assessment process, their will to collaborate, and the quality of their collaboration in any given case.

Prisoners may be transitioning to criminal justice services in the community or to community mental health services, each of which involves different agencies. In dysfuntional attempts of these agencies to collaborate across disciplines and services, their differences may be

invoked as reasons not to be involved in the process. For example, an agency may communicate, "We have different expertise and our expertise is not relevant for rehabilitation of this person" or "We don't have the resources the offender needs to get better". Such positioning, by these professionals, blocks constructive communication and problem solving and serves to maintain the status quo.

In contrast, a constructive approach would emphasise that different expertise and experience of different services, taken together, is a strength. This requires not looking at each other's strengths as a threat but, rather, as contributing to a joint understanding of that professional group and their contribution. For example, professionals from the prison where the person has been for a long time, and who may be involved in a transfer, may have the following to contribute:

- Detailed knowledge about the person.
- Solid understanding of risk relevance and risk scenarios.
- Expertise on risk management strategies that have functioned in the prison context.

Professionals in the receiving context (e.g. the community) may have

- Detailed knowledge about the new context.
- Some understanding of risk relevance and risk scenarios in the new context.
- Knowhow regarding the feasibility of the suggested risk management strategies in the new context.

The implications of this "collaboration complexity" will most likely cause confusion and frustration during collaboration processes, if "the meaning" of collaboration is taken for granted—for example, during the HCR-20^{V3} assessment. It is suggested that PINCOM may help professionals reflect on their understanding of collaboration through, for example, meta-communication processes in order to gain a better common understanding of what they might achieve together. However,

presently there is need for further exploration and research on interprofessional and interdisciplinary collaboration during HCR-20^{V3} assessment.

A main message in our chapter has been to emphasise a greater focus on the dynamics between the collaborating parties during HCR-20^{V3} assessment. This corresponds with the Norwegian Directorate of Health's recommendation that violence risk assessments should be carried out in an interprofessional collaboration context. And this is in contrast to the more conventional approach where only personnel in charge of a prisoner do the assessment. It is suggested that the inclusion of contextual factors during HCR-20^{V3} assessment, as provided by the participation of a range of service professionals, may be enhanced by using a differentiated perception of collaboration in line with the core content of PINCOM to enhance this joint assessment.

Employing the two tools, HCR-20 and PINCOM, in combination, as we illustrated in the case of Peter, can be considered a service delivery innovation (e.g., social innovation). "Social innovations are new solutions (products, services, models, markets, processes, etc.) that simultaneously meet a social need (more effectively than existing solutions) and lead to new or improved capabilities and relationships and better use of assets and resources. In other words, social innovations are both good for society and enhance society's capacity to act" (Murray et al., 2010, p. 18). In this regard, the combination of HCR-20 and PINCOM is a social innovative means of conducting risk assessment that may promote higher quality in the rehabilitation process, for both the offender and the professionals involved in the process.

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