RIP 2014 - 9th Regional Innovation Policies Conference
INNOVATION AND INNOVATION SYSTEMS IN SERVICES - PUBLIC AND PRIVATE
Topic: Collaborative innovation between organizations
Parallel Session 4 C: Room H-211 Friday 17/10/2014 11:00 – 12:45
Chair/discussant: Katja Maria Hydle

Social innovation to address offender mental health: building social relations between the mental health and criminal justice systems

Sarah Hean [1,3] Elisabeth Willumsen [1, 2] and Atle Ødegard [2,1]

1 University of Stavanger, Norway
2 University College Molde, Norway
3 Bournemouth University, UK

INTRODUCTION

Offender mental ill health is a major societal challenge with between 7 and 9 out of every 10 prisoners demonstrating signs of at least one mental disorder (Fazel & Baillargeon, 2011). This is far higher than the general population average and represents severe health inequality. A meta-analysis of 23 000 prisoners in 12 Western countries shows the severity of this problem reporting psychosis in around 4% of prisoners (compared to 1% in general population), major depression 10–12% (compared to 2-7), and personality disorder 42–65% (compared to 5-10-%) (Fazel & Baillargeon, 2011; Fazel & Danesh, 2002). Offender mental health is closely interwoven with physical ill health, substance misuse, wellbeing, ability to adjust to community life on release, social inclusion and reoffending. The latter places an economic strain on the public purse and prison/mental health hospital places. Offender mental ill health has knock on effects on the family, fellow prisoners, frontline police/court/prison staff and public safety (World Health Organisation, 2005).

The WHO (World Health Organisation, 2005) recommends improving interorganisational and Interprofessional collaboration to address these issues. However, diffferent professional groups and organisations do not always collaborate optimally, leading to a lack of continuity of care and serious errors in care. Collaborative practice at the interface of the MHS and CJS is particularly challenging due to the two very diverse cultures represented in these two overlapping systems

(Hean, Warr, and Staddon, 2009). But it is this diversity that lends itself socially innovative solutions to address mental health (Vangen & Huxham, 2013).

Social innovation is about taking new knowledge or combining existing knowledge in new ways or applying it to new contexts. These ideas are primarily about creating positive social change, improving social relations and collaborations to address a social demand. It requires professionals to be reflective and willing to cross organisational and disciplinary borders. Identified by the Lancet commission(Frenk et al., 2010) as a desirable competence in health and other professionals, being collaborative enables professionals be innovative to adapt to the ever complex and changing needs of service users within an interorganisational environment. Innovation is required to fill the grey spaces that lie between services other (Helse og Omsorg Departement, 2013) into which complex offenders fall when no agency takes responsibility for the offender or their mental health needs. Further, in the current economic climate, and cuts to public sector resources, different organisations must collaborate more effectively to achieve financial savings. Professionals must collaborate to find innovative ways of working to be cost effective and deploy resources differently. However, the concept of social innovation and the processes of coproduction inherently part of this are absent from the literature in this field.

This paper addresses this gap by exploring collaboration between services and professionals within the MHS and CJS through the lens of coproduction and social innovation frameworks. It considers examples of where coproduction between the MHS and CJS is evident and reframes these in terms of the type of innovation they represent. It contributes to the field of forensic mental health by providing insight and recommendations for managers in the MHS and CJS on how to encourage their professionals to actively engage in the innovation process, through coproduction across professional and organizational boundaries, in order to respond to the growing and changing needs of the mentally ill offender population.

DEFINITION OF SOCIAL INNOVATION

There is a wealth of information in the private sector context on innovation. Social innovation (conflated with public sector innovation) is a more recent phenomenon that borrows from conceptual thinking more established in the private sector whilst recognizing the fundamental differences between them. The most central difference is the emphasis on public value and social need in social innovations (Hartley, 2010).

The Guide to Social Innovation (European Commission, 2013) defines social innovation as:
"the development and implementation of new ideas (products, services and models) to meet social needs and create new social relationships or collaborations. It represents new responses to pressing social demands, which affect the process of social interactions. It is aimed at improving human well-being. Social innovations are innovations that are social in both their ends and their means. They are innovations that are not only good for society but also enhance individuals' capacity to act." (p6)

Bason, (2010) describes an ecosystem for innovation in the public sector setting out four key and interdependent dimensions:

- *Consciousness:* The degree to which workers within the public sector are aware of the concept of innovation and consciously striving towards achieving this in their practice.
- *Capacity:* The degree to which structures are in place within the organization that allow innovation to take place.
- *Cocreation/coproduction:* the collaborative processes that allow a cross fertilisation of different disciplinary perspectives and are necessary for innovative ideas to develop.
- *Courage:* A leadership environment able to facilitate the above dimensions (Bason, 2010).

The degree to which MHS and CJS professionals are aware of their roles as social innovators, as intrapreneurs (implementing and expanding on new ideas within their own organisations)(Wilson, Whitaker, & Whitford, 2012) the structures and leadership in place that facilitate innovation in these two systems or the nature of coproduction that may take place between MHS and CJS system is not yet understood. This paper addresses this shortfall by exploring one of these dimensions namely coproduction in the MHS/CJS context in more detail.

CONCEPTS OF COPRODUCTION.

Coproduction is the creation of outputs or outcomes that have added public value and is the result of positive joint activity between two or more actors (Alford, 2009). Coproduction is not necessarily only about direct interactions but occurs when the action of one agent (independently or in unison with the other agent), influences the action of another, creating altered output or outcomes as a result of this activity.

Coproduction is often used to describe the engagement of service users in the delivery and improvement of the services they receive from health and welfare organisations. However it is not

necessarily restricted to these agents and may equally apply to any two agents including interactions between professionals and organisations (Alford, 2009). Although coproduction with mentally ill offenders is important, we focus in this paper on the coproduction relationship between professionals and organisations. This is because this is a more manageable less complex area of collaboration to introduce quality improvement and a culture of innovation in the first instance, bearing in mind the vulnerability of mentally ill offenders and the challenges coproduction with this group may bring to the fore.

There is an element of interdependence in coproduction relationships. These differ from substitutive relationships where production is most effective if all the input into a particular activity in the organization (e.g. mental health screening) is all internally or all externally sourced and coproduction is not needed (Alford, 2009). Managers in the CJS for example may face the dilemma of whether it is more cost effective (in terms of human, time and financial resource):

- for the CJS to train police officers, prison wardens etc. to recognize and deal with mental health issues when encountered in the CJS)(all internal resource),
- for responsibility for mental health to lie entirely with MHS professionals/organisations who deliver services through assertive treatment programmes to screen and treat offenders whether they be in detention, care or the community (all external resource)
- for the MHS and CJS to collaborate actively to create joint protocols and other coproduced interventions to manage challenges facing mentally ill offenders (Coproduction).

It is the added value of this latter coproduction process and the potential benefits that may outweigh the resource (time, human, financial etc.) required that is of interest here. A small scale collaboration between a forensic psychiatrist in a US community based mental health treatment programmme and a probation officer of the U.S. federal prison system, (Roskes & Feldman, 1999) is a good example of these benefits of coproduction: Offenders on release are found often not to comply with their mental health treatment and hence are more likely to reoffend. The solution to this problem (and the output coproduced by these two professionals) was the creation of a formal collaboration or working protocol whereby the probation officer refers offenders on parole to the community health centre on release if mental health issues are evident. Contact and feedback between two professions is maintained and the probation officer kept abreast of attendance or progress of the person as they receive treatment. All patients are made aware of the close connection and frequent contact between the clinicians and the probation officer and the probation officer is included in any decision making related to the offender's attendance, treatment or care

plan. Evaluation of the outcomes of this joint activity showed greater compliance by offenders with treatment and hence better support for the mental health needs of offenders on federal probation, parole, supervised release, or conditional release in the community. These two professionals from the MHS and CJS respectively reported increased understanding of the knowledge domains and priorities of the other professional (Roskes and Feldman, 1999).

The relationship and protocol between the probation officer and psychiatrist represents a new way of working, a new social relationship that has clear social value for the offender and the general public. As such, it demonstrates some of the elements of social innovation discussed so far. The relationship is both the process and the product of coproduction activity. Increased treatment compliance, and potentially reduced recidivism may outweigh the costs of freeing time and resource for the psychiatrist and probation officer to work together and the two professionals should be encouraged to disseminate this protocol wider a field. There will be other reasons for these two professionals wanting to work together other than this cost benefits analysis however. They may be intrinsically motivated (Alford, 2009), both finding working together across organizational boundaries stimulating, that collaborating reduces professional isolation and collaboration may be a central and shared component of their professional values.

The above example illustrates the link between social innovation and social relationships and the coproduction that takes place within these relationships if managed correctly. The relationship between the probation officer and psychiatrist allows for a synthesis of distinct knowledge bases that come together during new social relations, allowing new knowledge and innovative ways of managing the transition of mentally ill offenders released on parole back in the community. Landry, Amara, and Lamari (2002) maintain that the overlap of distinct sources of knowledge is crucial in fostering innovation, and this knowledge is embedded within workplace networks and communities. They view innovation as a process rather than an event, occurring through sustained and often disorderly interactions between networks containing a diverse set of actors. Access to the knowledge held by these actors constitutes large stocks of social capital that offers a competitive advantage to organisations and individuals within these networks.

May want to add about complexity heoryThe way in which meaning is realised by each professional participating in the network may be described as a form of profession specific code (Beattie, 1995), a code that enables the professional group comes to understand their working environment and how they should behave within it. For the probation officer, for example, this code dictates how he

was able to make sense of the probation system in which he worked, what it means to be a probation officer and his actions within this system to maintain public safety and ensure compliance of his clients with the conditions of their parole. This code comprises the knowledge, skills and experiences that accumulate from being part of that profession and new knowledge is built on past knowledge from within the boundaries of the traditions and expertise of that discipline. Similarly, the psychiatrist treats mental illness in offenders based on the knowledge he has accumulated through training and practice and the knowledge is specific to this mental health discipline, accumulated and built upon over the centuries. This kind of knowledge is essential if current uniprofessional practices are to be delivered well and efficiently. However, this collective code can be distinguished and is complemented by what Beattie calls an integration code, i.e. the knowledge that is built from our learning from other disciplines. It is this integration code that social innovation must focus upon. Social innovation is achieved if the codes of each discipline can be accessed, examined and articulated by the other. The probation officer must seek to understand the code of the psychiatrist and vice versa. Each must be sufficiently reflective and willing to cross organisational and disciplinary borders to do so. That is illustrated in Roskes and Feldman (1999) where the probation officer and psychiatrist reflect on how regular contact between professions has lead to the psychiatrist developing an understanding of community supervision and the need to maintain public safety and the that the probation officer on the other hand now understands the mental health needs of his clients better and how mental health treatment works and is managed. Where cases of breach of supervision occur, for example, their coproduction and development of an integrated code enables them to work together to exhaust all treatment options, including voluntary and involuntary hospitalization, before sanctions on the offender are imposed.

This development of an integration code echoes Hammick, (1998) discussion of Bernstein's model of the categorisation of knowledge (Bernstein, 1971) in her discussion of the challenges of crossing interdisciplinary boundaries. In this model, there are collections of specialist knowledge known as singulars (e.g. psychosis), and those known as regions. Regions are several singulars bought together and as a result look towards a field of practice (e.g. psychiatry). Hammick (1998) argues for a third level of interprofessional knowledge arises from the transition of several regions into a 'new terrain of knowledge'. A new terrain of knowledge is possible if new knowledge is created in collaboration, if existing knowledge from each discipline is combined in new ways or if knowledge from one discipline is transferred/borrowed and applied to the new contexts of the other (Helse og Omsorg Departement, 2013). The creation of this new terrain of knowledge, and fertile ground for social innovation, is much more likely when an emphasis is placed by actors on developing an

integration code rather than a collection code; where professions from both the MHS or CJS are encouraged to draw widely on different types of knowledge they encounter when collaborating with professionals from the other discipline rather than (just) collecting knowledge from the heritage of their own. But by what processes can this new terrain of knowledge or integrated codes of knowledge be created or inhibited?

BARRIERS AND FACILITATORS OF COPRODUCTION AND SOCIAL INNOVATION

Although social innovation and coproduction are tightly interwoven, these are not without their challenges. Uniprofessional silos and power imbalances may work against these processes, for example. Professions or disciplines gain and maintain their roles and status via the specialist knowledge that underpins the services they offer. Possession of their own knowledge and thus the ability to do their work confers a social value on members of that discipline. Therefore, a psychiatrist has dominance over a set of knowledge pertaining to mental health and illness. This knowledge is not held by professionals within the CJS, (the probation officer for example), which gives the psychiatrist an element of power when interacting with the CJS. A barrier to collaborative practice arises if the psychiatrist fears that sharing their professional knowledge with probation means relinquishing professional power if the mysteries of one's own profession are shared. This fear counteracts the need for sharing their profession specific knowledge if professionals from the MHS and CJS are to combine resources and professional perspectives to cocreate new ways of managing an offender's mental health as they make the transition from prison back into the community (Roskes and Feldman, 1999).

Integrated codes arise from the presence of cultural diversity a key feature of social innovations but although areas potentially fertile in terms of social innovation, a number of perspectives brought to one table, often cased in language unfamiliar to all partners, can make these interactions very complex. Vangen & Huxham, (2013) describe what they call a quality tension between the positive potential of these culturally diverse interactions (complexity) versus the need for collaborators to simplify these interactions. They describe how organisations manage or simplify collaborations, either by choosing to collaborate only with those organisations similar to them in terms of working culture, or otherwise take the lead in collaborations in order to impose their working framework or agenda on other collaborators. In so doing, however, they run the risk of not fully benefiting from the diversity provided by other cultures. A review of interventions aimed at supporting the transition of mentally ill offenders from incarceration back into the community (Wilson and Draine, 2006) is an illustration of this. This review shows that whilst these reentry

interventions/strategies are developed in collaboration with the MHS, the majority of these are lead by the CJS. The authors suggest this demonstrates that the CJS is taking the majority of the responsibility for the mental health of the prison population, although the reason for this is unclear. Taken from Vangern and Huxham's perspective, however, one may hypothesise that the CJS may manage the complexity of dealing with the very different MHS culture by taking the lead in mental health strategies to help offenders reenter the community. However, the impact of this is that the MHS perspective and priorities are not accounted for, or underrepresented, and opportunities for an integrated code, and truly innovative reentry services to be coproduced by both systems, are lost.

The optimum lies in a balance of these two extremes. Perhaps in successful interactions, such as between the probation officer (a trained social worker) and the psychiatrist the balance has been found: the health and welfare professional perspectives are sufficiently different for innovation but sufficiently similar for communication and common ground to be achieved. But how different is too much as successful collaborations are reported in more diverse environments also. For example, Ryan & Mitchell (2011) describe an innovative complex needs unit, located within a young offender prison, developed and managed through regular multidisciplinary team meetings between prison wardens, mental health and other professionals that transfer prisoners from cells into the unit and develop individualised care plans. Reduction in unmet emotional needs and in high risk behaviours, and an improvement in peer relationships and engagement with the regime (Ryan & Mitchell, 2011) suggest interactions between these professions may have been positive and beneficial. However, in the absence of any controlled trial or deeper analysis of the quality of these collaborations in the evaluation, this cannot be assumed.

FOUR DIMENSIONS OF INNOVATION

So what is the relationship between collaboration, collaboration and social innovation within the discipline of forensic mental health? Some conclusions can be drawn by overlapping the four dimensions of social innovation with examples of collaboration and coproduction observed between the MHS and CJS reported in practice. The European Commission (2013) describe social innovation in terms of the four main elements:

1) Identification of new/unmet/inadequately met social needs

Offender mental ill health is a major societal challenge. In Europe, there are unacceptably high numbers of people in contact with the criminal justice system (CJS) who have mental health issues with almost 9 out of 10 prisoners demonstrating signs of at least one mental disorder (Marle and

Van, 2007). This is far higher than the average population level of mental illness and, as such, represents an area of severe health inequality within the Europe (World Health Organisation, 2005).

2) Development of new solutions in response to these social needs

A range of new practice models (social innovations) have developed in a process of coproduction between agents within the MHS and CJS aimed at addressing the shared problems associated with mentally ill offenders. Coproduction activity occurs at a number of levels:

- *Integration of knowledge bases:* At the most basic level micro level of analysis, coproduction between the MHS and CJS can be understood as an overlap of clinical and legal knowledge. For example legal and clinical knowledge frameworks have been synthesized by researchers (Cruise & Rogers, 1998) to develop assessment tools used to reliably test an offender's fitness to stand trial, taking into account the priorities of both systems in its development. Similarly, knowledge bases from the two disciplines are merged when recommendations are made to integration of mental health training into the syllabi of legal students (Mitchell, 2003) More pragmatically, knowledge bases are integrated when researchers describe efforts to map shared case loads across health and welfare services(Pandiani, Banks, & Schacht, 2001) to develop cross system maps of the mental health services and gaps within these (Rook, 2010) or to link administrative records from services from both systems to better plan interagency or interprofessional working (Hser & Evans, 2008). These activities may take place through direct interaction between individuals within each system (Rook 2010) or in isolation by individuals in one or the other agency although the activity of one has direct impact on the activity of the other (Cruise & Rogers, 1998).

- *Integration of treatments:* A second level of coproduction activity focuses on the multiple needs of the offender and comorbidity of mental illness and substance misuse. New approaches to delivering holistic and/or integrated services are suggested. Typical of these are Full Service Partnerships in the USA, community based interventions supporting the integration of support for housing, employment, education and health needs for individuals with co-occurring mental health and substance abuse disorders and who have extensive past-year histories of homelessness, incarceration, or inpatient or emergency psychiatric treatment (Starks, 2012).

- *Integration of professional activity:* A description of coproduction activity may not only focus on the output of the activity (e.g. models of treatment) but may also focus on the development of protocols that guide the process of production itself. For example, in the description of a complex needs unit for offenders in a young offender institution (Ryan & Mitchell, 2011), the importance and nature of regular interprofessional team meetings between prison wardens, mental health professionals and other professionals are described in the development of inter disciplinary care plans in a new approach to supporting young offenders with mental health issues. Interdisciplinary meetings are central also to workplace violence threat assessment and management practices. Professionals from security, law enforcement, mental health professionals, prosecutors, the courts and the state mental health system are brought together to successfully divert a mentally ill client in the workplace from a path of intended violence (Farkas & Tsukayama, 2012).

- *Integration of services:* At the most macro level, literature focuses on coproduction activity at an organizational level, typified by Appelbaum, Manning, & Noonan, (2002) 's description of the benefits and challenges of a new partnership between a university medical school, a private vendor of mental health services and a department of correction in the treatment of mentally ill.

Whichever the level of coproduction activity, these activities between the MHS and CJS occur at various points throughout the mentally ill offender's trajectory through the criminal justice system. These occur when the offender is:

- *In the community:* (prior or at arrest or upon release). These are interventions that aim for continuity of mental health care for the offender upon release from prison or work with individuals living with a mental health issue that have a history of offending behavior. The aims are to prevent them reoffending or to divert them into mental health care before they offend or at the point of arrest. Interactions between the probation and mental health services (Kolko, Noel, Thomas, & Torres, 2004, Roskers and Feldman,1999;) and between the police and mental health services (Cross Brown et al., 2014)(Kasick & Bowling, 2013)(El-Mallakh, Spratt, Butler, & Strauss, 2008) are required in these contexts.
- *When at Court* (post arrest during occur proceedings). Mental health may have a direct influence on the offence initially committed in addition to the ability of the offender to comply with the sentence imposed (if a community based sentence). Further, if

incarceration is required, prison may not always be the most appropriate place for a mentally ill offender. Co-operation between court officials and health and welfare professionals is required to make these judgments. Mental health courts (Thomas, 2003) and Diversion and Liaison schemes (Salina, Lesondak, Razzano, & Weilbaecher, 2007, Green, Smith, & South, 2005, Smith, Jennings, & Cimino, 2010) are interventions that facilitate these interactions.

- *During Detention* (either in jail, prison or medium and high secure units/hospitals). Finally, with 7-9 of all prisoners suffering a mental illness of some form, cooperation is required between prison wardens and the mental health services in the screening, treatment and ensuring the compliance of offenders with their mental health treatment (Aalsma Schwartz and Perkins 2014; Ryan & Mitchell, 2011; Cooke and Cooke, 1982).

The location of the collaboration aside, coproduction may also be classified by the type of output it achieves. So for collaborations between the MHS and CJS actors these outputs may be:

- *screening for and treatment of mental heath conditions* (this can occur during court proceedings (Green, Smith, & South, 2005) or during detention (Aalsma, Schwartz, & Perkins, 2014)(Ogloff, Tien, Roesch, & Eaves, 1991).
- *diversion of offenders away from the CJS and into the mental health services* either at the point of arrest (Franz & Borum, 2011) McGuire & Bond, 2011, El-Mallakh, Spratt, Butler and Strauss 2008;(Teller, Munetz, Gil, & Ritter, 2006) or during their court proceedings (Smith, Jennings, & Cimino, 2010; Green, Smith, & South, 2005). Similarly severely mentally patients may be removed from their prison environment and into separate high security mental health units for care (Ryan & Mitchell, 2011).
- *management of transitions either into or out of detention.* Here cooperation between the MHS and CJS is required to ensure offenders receive continuous mental health treatment upon release ((Kinner, 2006; A. B. Wilson & Draine, 2006), or that medication they receive, when in the community, is continued when they enter detention (Hassan, Senior, Edge, & Shaw, 2011; Ogloff et al., 1991).
- *prevention of reoffending through mental health treatment in the community:* these include models based on assertive community treatments (ACTs), where offenders on release from prison receive treatment as outpatients for their treatment (Starks, 2012).

Some interventions will agave a combination of these outputs.

Lastly, Hartley's typology of social innovations (Hartley, 2010) may be applied to the areas of collaboration between the MHS and CJS. Collaboration may lead to a range of social innovations including:

- *Product innovation:* in the MHS/CJS realm this involves the development of new shared record keeping systems, cross system databases or whereby shared case load between welfare, health and criminal justice systems are established to facilitate improved interprofessional working and more holistic care delivered to offenders who often have multiple needs in addition or caused by their mental health issue (Hean, Heaslip, Warr, Bell, & Staddon, 2010; Rook, 2010, Hser and Evans, 2008; Wilson and Draine, 2006,)

- *Service innovations:* these are new ways in which services are provided to users. This is illustrated by the development of a complex needs unit (Ryan & Mitchell, 2011) in a young offending institution. To better deal with juveniles in detention with a mental health issue, rather than routine health care, a separate complex need unit was developed in collaboration between prison officers and mental health staff. The unit is staffed by prison officers with input from the mental health team (including mental health nurses and psychologists) and other professionals such as teachers and caseworkers.

- *Positional innovations*: where an innovation may be applied to a new context or service user. This is illustrated by the application of the Crisis intervention team training previously used to train police officers to deescalate a mentally ill individual in crisis in the community It is proposed (Tucker, Hasselt, Mendez, Palmer, & Browning, 2012) that this training be transferred into the jail system, where similar CIT training is being given to police offers to descale crisis situations involving the mentally ill within prison.
- *Process innovations:* new organizational processes.
- *Strategic innovations*: new goals or purposes being set for the organization. A report of new partnerships between a university mental health department, a private provider of health care and a Department of correction in the US by Appelbaum, Manning and Noonan (2002 is an example both of new organisational processes on how services should be provided but also about the strategic direction of all three organisations.
- *Governance innovation:* This is illustrated by new guidelines outlining a systematic approach to the delivery of integrated and continuous care for offenders during and after

incarceration through guidelines aimed at both professionals within the criminal justice system and in community-based treatment programs ensuring continuity of care for the offender as they pass between systems (Center for substance abuse treatment., 1998).

- *Rhetorical Innovation: the* development of new language or concepts. Some coproduction/collaborations between the MHS and CJS do not call so much for the interaction and collaboration between professionals or organisations but instead for the overlap of knowledge and interdisciplinary thinking. This is illustrated by calls for the training of lawyers in include element of mental health in their curriculum (Mitchell, 2003), that social workers integrate knowledge of legal frameworks, into their generalist social work practice skills (Cooke and Cooke, 1982) and for the integration of legal and mental health clinical knowledge (Cruise & Rogers, 1998) in the development of new assessment frameworks required to assess if an offender is mentally fit to stand trial.

Any one intervention may be a combination of one or more of these types of innovation.

3) Evaluation of the effectiveness of new solutions in meeting social needs

Evaluations focus on a wide range of patient/offender outcomes (including reoffending rates and mental health outcomes). It is not yet possible to determine from evaluation of MHS/CJS interactions in the literature, the quality and quantity of collaboration between professionals or services and the direct contribution this has made on offender outcomes. The actual and optimum level of structural integration between services remains unmeasured although Ahgren & Axelsson, (2005) would suggest this optimum will vary from context to context and patient group to patient group. Similarly little is known of actual and optimum levels of coproduction between the MHS and CJS or of the relationship between structural integration and level of coproduction and when and where coproduction is a necessity. Strong evidence in the form of randomised control trials are scarce, and difficult to implement logistically and ethically. Interventions tend to have small sample sizes, often relying on service held records, which are often inconsistently maintained.

4) Scaling up of effective social innovations.

Hartley states that spreading good practice, adaption and adoption of existing innovation to different times or contexts is a significant element of public sector innovation (Hartley, 2010). A critique of many reports of co productive activity between MHS and CJS is the small-scale nature of the interventions developed. One off or locally based interventions are most often described (e.g. Aalsma Schwartz and Perkins 2014; Farkas and Tsukayama, 2012, Appelbaum, Manning and

Noonan, 2002, Roskes and Feldman, 1999) with no evidence of the success of the interventions being disseminated (other than in a single article or report). These smaller interventions should not be dismissed however, as they may represent areas of bricolage, a concept used by Fuglsang (2010) that distinguishes managerially lead more radical innovation, from the tinkering or small adaptive processes or innovations where by professionals on the ground adjust given protocols or pressures in small incremental ways to improve their practice.

The importance of implementation is well illustrated by the implementation of an innovation specifically designed to improve collaboration between health and welfare services. In Norway, the individualized care plan, implemented since 2001, is a radical innovation engineered by the department of health and welfare to promote the integration of care and services and user involvement in the care of people living with complex and long term conditions. Holum, Mental, & Eastern, (2012), albeit in the realm of mental health services alone, show a wide variation in the dissemination, adaptation and implementation processes of this innovation. There is great variation and limitation in the ways in which innovation has been disseminated by government as well as managers. Organizational culture (e.g. perceived value of IP tool; negative attitudes) to change is key to implementation of this innovation, as have factors such as a lack of role clarity as to who should be coordinating the plan, the lack of financial support behind use of tool and administrative issues (e.g. time taken to do plan). If we are to understand how collaboration takes place between MHS and CJS, we need to understand how innovations, especially ones like this that are directly aimed at improving collaboration are implemented in practice if they are to succeed.

There are some exceptions to the lack of scaling up of small innovations within MHS and CJS collaborations. Two examples described here are that of diversion and liaison schemes in the UK and Crisis intervention teams in the USA.

Crisis Intervention Teams

These are diversion schemes whereby specialised police officers are trained to recognize mental health issues and de-escalate a mentally ill person in crisis in the community. Instead of arrest, these officers aim to divert individuals into the mental health services. The intervention originated in Memphis, USA, where a young man with Schizophrenia in crisis, attacked on police officers and was shot and killed. This is indicative of a wider problem of the threat severely mentally ill subjects in the community pose to themselves, community services and public safety if support and treatment is not obtained.

The solution came from a partnership formed between the Memphis Police Department and the National Alliance for the Mentally Ill to develop the Memphis Model of crisis intervention team training. This involved the training of specialized police officers in mental health issues and the community resources they may call upon that relate to mental health. This training gave police officers the skills to recognize mental health issues in individuals, skills to descale a crisis event and the knowledge of which community and other resources to take the individual to for treatment. These are a form of diversion service redirecting the subject in crisis away from arrest and the criminal justice system and into mental health services instead (Tucker, Mendez, Browning, Van Hasselt, & Palmer, 2012). This model was evaluated and found to be associated with reduced arrest rates, reduced injuries to police and subjects, and fewer jail suicides. (Tucker, Mendez, et al., 2012). The dissemination and implementation of this model is clearly evident being spread to other geographical locations within the US (Cross, Mulvey, Schubert, Griffin, Filone, Winckworth-Prejsnar, ,Dematteo and Heilbrun, 2014; Franz and Borum, 2011, McGuire & Bond, 2011, El-Mallakh, Spratt, Butler and Strauss 2008; Teller, Munetz, Gil and Ritter, 2006) as well as into other care contexts (for example jail settings and training of detention officers in this environment (Tucker, Mendez, et al., 2012).

The Crisis intervention team intervention is a clear example of social innovation bearing the characteristics of repetition and dissemination offered by Fuglsang (2010) or of the four dimensions of problem identification, solution, evaluation and dissemination put forward by the European Commission (2013).

Diversion and liaison schemes

These services are characterised by mental health workers being physically located in the court building and represent collaborations between the mental health and criminal justice system aiming to divert offenders with severe mental health problems away from prison and into mental health services. These provide screening and mental health assessment for offenders in court and facilitate information flow to prosecutors, probation, magistrates etc. as well as providing relevant signposting to health and social care services when appropriate (Clapper, 2012). Anticipated outcomes include reduced court delays leading to fewer adjournments, an increase in the screening of mental health issues in this population and better defendants support. Designing this innovation and putting this into action requires building of new relationships between police, lawyers, judges, and ushers on the one hand in the CJS and with mental health nurses, psychiatrists,

psychologists and social workers in the MHS on the other. Previously these professionals have been geographically and organisationally separated from each other (Hean et al., 2009). Although evaluations are hampered by poor or consistent record keeping in these services and low sample numbers, outcomes such as increase in time between release and reoffending for individuals accessing these services and improved mental health outcomes are evident (University of Liverpool, 2012). A large scale governmental review of services for people with mental health or learning disabilities in prison in England and Wales (Bradley, 2009) led to the scaling up of these small scale innovations through a National Diversion Programme aiming to roll out liaison and diversion services for all police custody suites and courts across England and Wales by 2014. It is up to management now to innovate and create locally relevant collaborations between the court and mental health professionals working within this environment, in intentional or semi-intentional innovations (Fuglsang, 2010).

THE WAY FORWARD: PROMOTING INNOVATION AT THE INTERFACE OF THE MHS AND CJS:

There is a need to encourage professionals to engage in coproduction activity at a range of levels to come up with socially innovative solutions to the disjuncture between MHS and CJS services. Coproduction and innovation is seldom mentioned explicitly in the research or practice development literature. There is a lack of evidence supporting the determinants of successful collaborations between the MHS and CJS, especially that in which coproduction and socially innovation are explicit processes. For example, in innovations that are designed to improve collaboration and integration explicitly (such as the Norwgian individualised plan). There is indication that there is some resistance across the mental health services alone (Holum et al., 2012), but no indication yet of how this is playing out in mental health services serving the offender population, nor how the innovation is being implemented across the MHS/CJS organizational borders. Research is required to explore and develop instrumentation that measures the incidence, level and nature of coproduction activity and social innovation between the MHS and CJS the relationship between them, as well as the implementation (dissemination, adaptation and adoption processes) as they play out across organizational boundaries.

Framing the collaborations between the MHS and CJS in terms of coproduction and social innovation leads to a range of possibilities, requiring future research and development, including:

- Promoting in MHS/CJS professionals an awareness of what it means to be social innovative and of the benefits and processes that encourage or detract from successful collaboration.

- Developing a balance between the forces for complexity and simplicity when the culturally diverse MHS and CJS interact.
- Promoting coproductivity over and above simple coordination and cooperation
- Scaling up successful collaboration models, formalizing the repetition and dissemination of bricolage innovations.
- Providing the location or structures that allows coproduction activity and social innovation to take place.
- Achieving a balance between organisational flexibility to allow collaborations to occur and innovations to grow from these and the necessary rigidity of structures required to maintain working order (Vangen & Huxham, 2013).
- Achieving a balance between giving professionals sufficient autonomy to be trusted to represent the interests of the organization versus the need to account for their actions to their employer (Vangen & Huxham, 2013).
- Developing leaders that are competent in achieving these structures and conditions (Hartley, 2010).

Appropriate training is also key in promoting co-production of knowledge between disciplines and eventually social innovation. Professional education is not just a process of gaining professional knowledge and skills: it is a process of socialisation into the values and characteristics of a particular profession and what professionalism means to this group. To be able to co-create these new terrains or integrated codes of knowledge, professionals from the MHS and CJS both need to have values and competencies that allow them to collaborate with other disciplines, to reflect and articulate their own codes and regions of knowledge, interrogate that of other disciplines and work with others disciplines effectively to create a new terrain of knowledge synthesized from the two disciplines together. It is from within this terrain of knowledge that social innovation lies. The Lancet Commission (Frenk et al., 2010) in laying out the direction for health profession education in the 21st Century describes a new professionalism characterized by collaborative values and collaborative competencies. It recognises that whilst educational systems cannot predict the population health and social welfare needs of the future, it can give future professionals the skills to be socially innovative and ready to respond to population needs within a rapidly changing health care environment that is increasingly complex and specialized. Professionals must be able to cross-disciplinary boundaries, by interacting with new disciplines and contexts with reflexivity and flexibility.

One model of this type of training are crossing boundary workshops for the MHS and CJS professional, currently in early stages of development in the MHS/CJS field (Hean et al., 2012). These workshops draw on Engeström's activity system triangles to articulate theoretically the components of the MHS systems and CJS systems respectively and explore where contradictions in the two systems lie when they overlap as they do when offender mental health is an issue (Engeström, 2001). In Engeström's crossing boundary workshop method a real life case study or authentic form of practice is used as a mirror to participants' experiences of interprofessional working between the MHS and CHS. This stimulates a discussion in which contradictions are identified and joint solutions cocreated. Participants return to practice to test out the innovative solution, returning at later stage to evaluate and reform the solution if necessary (more on this theoretical approach to the workshop design is reported elsewhere (Hean et al., 2012). This crossing boundary workshop model is a method whereby awareness of and process of innovation and coproduction can be encouraged between MHS and CJS services. These can be used both as vehicles of semi intentional innovation as well as bricolage where either emerging problems in collaborative practice are identified by MHS and CJS managers together and formalized projects arranged around them or where frontline MHS and CJS professionals can share their every day collaboration needs and share personal experiences of how these may have been resolved or policy and managerial directives adapted to their individual context and patients.

These workshops also provide a potential location to promote collaborative competencies and values. Examples of the values for these future professionals are an acceptance of team working and collaborative practice, curiosity, empathy and respect, a willingness to respectfully challenge others and an honesty and openness about one's own beliefs (Frenk et al., 2010)(Christmas & Millward, 2011). Similarly collaborative competencies frameworks have been developed that spell out the dimensions of collaborative competence (Wilhelmsson et al., 2012; Interprofessional Education Collaborative., 2011, Orchard & Bainbridge, 2010; ; Walsh, Gordon, Marshall, Wilson, & Hunt, 2005). These include competencies related to the ability to articulate ones own and interrogate the roles and responsibility of other disciplines, understanding the legal constraints of other disciplines, a grasp of concepts of shared and collaborative leadership and the ability to manage interdisciplinary, interprofessional and interagency interactions.

Some of these suggestions are currently explored in an ongoing Marie Curie EU funded study (2014-2016) into the determinants of collaboration and social innovation between the MHS and CJS. A key deliverable is the development of a pedagogical framework to underpin training that

prepares MHS and CJS professionals to deliver collaborative practice, deliver better services and improve the mental health of the offender population. This project explores collaboration in Norway as a case study but has a long-term transferability across the EU and other clinical contexts.

CONCLUSION

In this paper we have explored in the context of collaboration between the mental health and criminal justice worker, the concept of coproduction and social innovation. Exploring these collaborations through the lens of coproduction and innovation, a range of research and practice based recommendations have been put forward including the need to improve the evidence base underpinning collaborative practice, as well as a proposed model of training which has the potential, with further development, to promote innovation awareness and competence and collaborative competence. In combination these skills will enable professionals to work together, and in collaboration with the offender, to coproduce socially innovative solutions to the high level of mental illness in the offender population.

REFERENCES

Aalsma, M. C., Schwartz, K., & Perkins, A. J. (2014). A statewide collaboration to initiate mental health screening and assess services for detained youths in indiana. *American Journal Of Public Health*, *104*(10), e82–e88. doi:10.2105/AJPH.2014.302054

Ahgren, B., & Axelsson, R. (2005). Evaluating integrated health care: a model for measurement. *International Journal of Integrated Care*, *5*(August), e01; discussion e03, e09. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1395513&tool=pmcentrez&rendertype=abstract

Alford, J. (2009). *Engaging Public Sector Clients*. Baingstoke: Palgrave.

Appelbaum, K. L., Manning, T. D., & Noonan, J. D. (2002). A university-state-corporation partnership for providing correctional mental health services. *Psychiatric Services*, *53*(2), 185–189. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2002-10591-004&site=ehost-live

Bason, C. (2010). *Leading public sector innovation*. Bristol: Policy Press.

Bernstein, B. (1971). *Class, codes and control.,*. London: Routledge.

Bradley, Lord. (2009). *The Bradley Report*. London: Department of Health. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

Center for substance abuse treatment. (1998). Continuity of Offender Treatment for Substance Use Disorders from Institution to Community. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=22514836&site=ehost-live

Christmas, S., & Millward, L. (2011). New medical professionalism, (October).

Clapper, A. (2012). *Mapping Liaison and Diversion Services for Hampshire and the Isle of Wight A Report for NHS South of England Andy Clapper Andican Consultancy List of Contents*. Lymington: Andican Consultancy.

Cross Brown, A., Mulvey P, E., Schubert A, C., Griffin A, P., Filone, S., Winckworth-Prejsnar, K., … Heilbrun, K. (2014). An agenda for advancing research on crisis intervention teams for mental health emergencies. *Psychiatric Services*, *65*(4), 530–536. doi:10.1176/appi.ps.201200566

Cruise, K. R., & Rogers, R. (1998). *An analysis of competency to stand trial: an integration of case law and clinical knowledge*. *Behavioral Sciences & the Law* (Vol. 16, pp. 35–50). John Wiley & Sons, Ltd. 2004. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=11818691&site=ehost-live

Departement i Helse og Omsorg. (2013). *Morgendagens omsorg: Norwegian Governement White Paper no. 29*. Norway: Helse og Omsorg Departement.

El-Mallakh, R. S., Spratt, D., Butler, C., & Strauss, G. (2008). Evaluation of consequences of implementation of police crisis intervention team in Louisville. *The Journal Of The Kentucky Medical Association*, *106*(9), 435–437. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=18828335&site=ehost-live

Engeström, Y. (2001). Expansive Learning at Work: Toward an activity theoretical reconceptualization. *Journal of Education and Work*, *14*(1), 133–156. doi:10.1080/13639080020028747

European Commission. (2013). *Guide to social innovation*.

Farkas, G. M., & Tsukayama, J. K. (2012). An integrative approach to threat assessment and management: Security and mental health response to a threatening client. *Work: Journal of Prevention, Assessment & Rehabilitation*, *42*(1), 9–14. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2012-14773-004&site=ehost-live

Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *Lancet*, *377*(9769), 956–65. doi:10.1016/S0140-6736(10)61053-7

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet*, *359*(9306), 545–50. doi:10.1016/S0140-6736(02)07740-1

Franz, S., & Borum, R. (2011). Crisis intervention teams may prevent arrests of people with mental illnesses. *Police Practice & Research: An International Journal*, *12*(3), 265–272. Retrieved from 10.1080/15614263.2010.497664

Frenk, J., Chen, L., Bhutta, Z. a, Cohen, J., Crisp, N., Evans, T., … Zurayk, H. (2010). Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*, *376*(9756), 1923–58. doi:10.1016/S0140-6736(10)61854-5

Fuglsang, L. (2010). No TitleBricolage and invisible innovation in oublic service innovation. *Journal of Innovation Economics*, *5*, 67–87.

Green, G., Smith, R., & South, N. (2005). Court-based psychiatric assessment: Case for an integrated diversionary and public health role. *Journal of Forensic Psychiatry & Psychology*, *16*(3), 577–591. Retrieved from 10.1080/14789940412331313160

Hartley, J. (2010). and Present Innovation in Governance and Public Services : Past and Present, (September 2014), 37–41. doi:10.1111/j.1467-9302.2005.00447.x

Hassan, L., Senior, J., Edge, D., & Shaw, J. (2011). Continuity of supply of psychiatric medicines for newly received prisoners. *The Psychiatrist*, *35*(7), 244–248. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-24425-002&site=ehost-live

Hean, S., Heaslip, V., Warr, J., Bell, H., & Staddon, S. (2010). A women's worker in court: a more appropriate service for women defendants with mental health issues? *Perspectives in Public Health*, *130*(2), 91–96. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2010652858&site=ehost-live

Hean, S., J. Warr, & Staddon, S. (2009). Challenges at the interface of working between mental health services and criminal justice system. *Medicine, Science and the Law*, *49*(3), 170–178.

Hean, S., Staddon, S., Clapper, A., Fenge, L.-A., Jack, E., & Heaslip, V. (2012). INTERAGENCY TRAINING TO SUPPORT THE LIAISON AND DIVERSION AGENDA. Bournemouth, UK: Bournemouth University and SW Offender Health.

Holum, L. C., Mental, A., & Eastern, H. (2012). " It is a good idea , but …" A qualitative study of implementation of " Individual Plan " in Norwegian mental health care, *12*(March).

Hser, Y.-I., & Evans, E. (2008). Cross-system data linkage for treatment outcome evaluation: lessons learned from the California Treatment Outcome Project. *Evaluation And Program Planning*, *31*(2), 125–135. doi:10.1016/j.evalprogplan.2008.02.003

Interprofessional Education Collaborative. (2011). Core Competencies for Interprofessional Collaborative Practice, (May).

Kasick, D. P., & Bowling, C. D. (2013). Crisis Intervention Teams: A boundary-spanning collaboration between the law enforcement and mental health communities. In K. R. Yeager, D. L. Cutler, D. Svendsen, & G. M. Sills (Eds.), *Modern community mental health: An interdisciplinary approach.* (pp. 304–315). New York, NY, US: Oxford University Press. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2013-08779-021&site=ehost-live

Kinner, S. A. (2006). Continuity of health impairment and substance misuse among adult prisoners in Queensland, Australia. *International Journal of Prisoner Health*, *2*(2), 101–113. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-21010-003&site=ehost-live

Kolko, D. J., Noel, C., Thomas, G., & Torres, E. (2004). Cognitive-behavioral treatment for adolescents who sexually offend and their families: individual and family applications in a collaborative outpatient program. *Journal Of Child Sexual Abuse*, *13*(3-4), 157–192. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=15914395&site=ehost-live

M. Hammick. (1998). Interprofessional education: Concept, theory and application. *Journal of Interprofessional Care*, *12*, 323–332.

Marle, E. B., & Van, H. J. C. (2007). Mental Health in Prisons. In *Health in Prisons: A WHO Guide to essentials in prison health* (Vol. 196). Copenhagen: World Health Organization : Copenhagen. doi:10.1016/S0140-6736(01)00242-2

McGuire, A. B., & Bond, G. R. (2011). Critical elements of the crisis intervention team model of jail diversion: An expert survey. *Behavioral Sciences & the Law*, *29*(1), 81–94. doi:10.1002/bsl.941

Mitchell, D. B. (2003). Building a multidisciplinary, collaborative child protection system: The challenge to law schools. *Family Court Review*, *41*(4), 432–435. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2003-08484-001&site=ehost-live

Nursing, M. H. (2003). Thomas, S. P. (2002). From the editor—The mental health court: An idea whose time has come. Issues in Mental Health Nursing, 23 , 733. 461, (2002). doi:10.1080/01612840390208015

Ogloff, J. R., Tien, G., Roesch, R., & Eaves, D. (1991). A model for the provision of jail mental health services: An integrative, community-based approach. *Journal of Mental Health Administration*, *18*(3), 209–222. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1992-17596-001&site=ehost-live

Orchard, C. A., & Bainbridge, L. A. (2010). *A National Interprofessional Competency Framework*. Vancouver: Canadian Interprofessional Health Collaborative.

Pandiani, J. A., Banks, M., & Schacht, L. M. (2001). Caseload Segregation / Integration and Service Delivery Outcomes for Children and Adolescents.

Rook, D. M. (2010). *Cross-systems mapping as a collaborative tool for the mental health and criminal justice systems. Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning, US. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-99240-172&site=ehost-live

Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness. *Psychiatric Services*, *50*(12), 1614–1619. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2000020494&site=ehost-live

Ryan, T., & Mitchell, P. (2011). A collaborative approach to meeting the needs of adolescent offenders with complex needs in custodial settings: An 18-month cohort study. *Journal of Forensic Psychiatry & Psychology*, *22*(3), 437–454. Retrieved from 10.1080/14789949.2011.586042

Salina, D. D., Lesondak, L. M., Razzano, L. A., & Weilbaecher, A. (2007). Co-Occurring Mental Disorders Among Incarcerated Women: Preliminary Findings from an Integrated Health Treatment Study. *Journal of Offender Rehabilitation*, *45*(1/2), 207–225. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=eric&AN=EJ844582&site=ehost-live

Smith, R. J., Jennings, J. L., & Cimino, A. (2010). Forensic continuum of care with assertive community treatment (ACT) for persons recovering from co-occurring disabilities: Long-term outcomes. *Psychiatric Rehabilitation Journal*, *33*(3), 207–218. doi:10.2975/33.3.2010.207.218

Starks, S. L. (2012). *Cost and effectiveness of full service partnerships: Assertive community treatment of severe mental illness following the California Mental Health Services Act. Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning, US. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2012-99240-418&site=ehost-live

Teller, J. L. S., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services*, *57*(2), 232–237. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2009186416&site=ehost-live

Tucker, A. S., Hasselt, V. B. Van, Mendez, J., Palmer, L., & Browning, S. L. (2012). Crisis Intervention Team (CIT) Training in the Jail / Detention Setting : A Case Illustration, *14*(3), 209–216.

Tucker, A. S., Mendez, J., Browning, S. L., Van Hasselt, V. B., & Palmer, L. (2012). Crisis intervention team (CIT) training in the jail/detention setting: a case illustration. *International Journal Of Emergency Mental Health*, *14*(3), 209–215. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=23894801&site=ehost-live

Vangen, S., & Huxham, C. (2013). BUILDING AND USING THE THEORY OF COLLABORATIVE ADVANTAGE. In R. Keast, M. Mandell, & R. Agranoff (Eds.), *Building and Using the Theory of Collaborative Advantage. In Network Theory in the Public Sector: Building New Theoretical Frameworks*. New York, NY: Taylor and Francis.

Walsh, C. L., Gordon, M. F., Marshall, M., Wilson, F., & Hunt, T. (2005). Interprofessional capability: a developing framework for interprofessional education. *Nurse Education in Practice*, *5*(4), 230–237. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2009012324&site=ehost-live

Wilhelmsson, M., Pelling, S., Uhlin, L., Lars, O. D., Faresj, T., & Forslund, K. (2012). How to think about interprofessional competence: A metacognitive model. *Journal of Interprofessional Care*, *26*(2), 85–91. doi:10.3109/13561820.2011.644644

Wilson, A. B., & Draine, J. (2006). Collaborations Between Criminal Justice and Mental Health Systems for Prisoner Reentry. *Psychiatric Services*, *57*(6), 875–878. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=16754768&site=ehost-live

Wilson, A., Whitaker, N., & Whitford, D. (2012). Rising to the challenge of health care reform with entrepreneurial and intrapreneurial nursing initiatives. *Online Journal Of Issues In Nursing*, *17*(2), 5. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=22686113&site=ehost-live

World Health Organisation. (2005). MENTAL HEALTH AND PRISONS: information Sheet, 1–6. Retrieved from http://www.who.int/mental_health/policy/mh_in_prison.pdf

Sarah Hean, Elisabeth Willumsen and Atle Ødegard

Paper in Progress presented at 9th Regional Innovation Policies Conference - RIP 2014, University of Stavanger