Collaboration, Coproduction and Social Innovation

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INTRODUCTION

This chapter presents a view of social innovation as a process of knowledge coproduction between interdisciplinary actors. It offers theoretical perspectives of knowledge classification and activity theory as a means of understanding this process. It provides recommendations on how the public sector workforce may be prepared to engage in coproduction to achieve social innovation, considering some of the values and competencies they require and practical ways, through transformational learning and crossing boundary workshops, to achieve this. We present this within the context of a case study social innovation, achieved through collaboration and the coproduction of knowledge between mental health and criminal justice systems collaborating to develop social innovations to address poor mental health in offender populations.

DEFINING SOCIAL INNOVATION

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)

It is the premise of this chapter that social innovation not only creates new social relationships or collaborations but that it the product of the synthesis and coproduction of new knowledge that new social relations and interdisciplinary collaborations encourage. This is supported by Landry, Amara, and Lamari (2002) who maintain that knowledge plays a crucial role 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. A survey of industry's propensity to engage in innovation or not, shows dimensions of social capital, such as levels of participation in meetings (with associations, industry partners etc) and strong working relationships with a wide range of diverse actors (from business, government, universities etc.), to be strongly predictive of whether organisations engaged in innovation in the first place. The radical nature of this innovation, once engaged upon, depends on levels of information accessed in interactions with so called research assets (e.g. university and research organisations) (Landry, Amara, and Lamari, 2002).

A case study

Before looking at the concept of knowledge production and coproduction that occurs within collaborations between diverse actors within the public sector, the chapter presents a case study to ground its discussion. It presents the social needs of the offender population in Europe to achieve this.

Social innovation has four main elements (European Commission 2013):

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. If offender mental health is not addressed, this leads to:

- Deterioration of the mental disorder, impacting on offender wellbeing.

- Offenders not adjusting to community life on release resulting in their social inclusion and reoffending.
- The CJS imposing inappropriate sentences on offenders.
- Knock on effects on wellbeing of offenders' family, fellow prisoners, frontline police/court/prison staff and public safety.
- As mentally ill offenders are likely to reoffend, an economic strain on the public purse and prison and mental health hospital places (World Health Organisation, 2005).

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

There is a range of new practice models aimed at reducing mental illness in offenders. These include diversion and liaison schemes, specialist mental health courts, care coordination and service level agreements (Bradley, 2009). These interventions may be viewed as social innovations taking the form of service reorganisations to address this social need of the offender population. Innovation is required to fill the grey spaces that lie between services (Helse og Omsorg Departement, 2013) into which complex offenders fall when no agency takes responsibility for the offender or their mental health needs.

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. This leads to a lack of continuity, and serious errors in care. Collaborative practice at the interface of the MHS and CJS is particularly challenging (Hean, Warr, and Staddon, 2009), lacking shared protocols and agreed timeframes, poor information sharing and lack of clarity on lines of responsibility. However, effective partnership working between these systems is needed for the design of socially innovative interventions that promote early diagnosis of the offender, treatment, appropriate sentencing or diversion into the MHS. Focussing on diversion/liaison schemes in particular: these are models of collaboration between the MHS and CJS leading to some courts having a mental health worker in court. This dedicated mental health worker means court personnel should be able to obtain mental health expertise otherwise unavailable. Hereby immediate and up to date information on the mental health of the defendant and information that contributes to bail and sentencing decisions is forthcoming. This should reduce delays leading to fewer adjournments, increase the screening of mental health issues in this population and offer defendants support. Designing this innovation and putting this into

action requires building of new relationships between police, lawyers, judges, 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.

The growing liaison/diversion agenda has many implications, not least for workforce planning that must now take into account the training needs of professionals already in the criminal justice and mental health systems as well as those of new professionals entering these in the future. There will be an increased requirement for mental health staff in particular to work more closely with the criminal justice agencies, particularly police, courts and probation and they will need to have knowledge about the liaison and diversion agenda and partnership agencies to be able to make an informed choice to apply for future posts that include explicitly working with offenders.

Exploring the production and coproduction of knowledge at the MHS/CJS Interface is required to enhance collaboration between these actors and indirectly the social innovation they can hope to achieve.

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

Published reports of the evaluation of these diversion/liaison schemes as social innovations are somewhat limited but the few have shown that well-designed arrangements for diversion/liaison have the potential to yield multiple benefits, including cost and efficiency savings within the criminal justice system, reductions in re-offending and improvements in mental health (Sainsbury 2009). These interventions are complex and non linear in nature, as in many social innovations, and the collaborative learning that occurs within these is sometimes unpredictable. As such, these interventions lend themselves to realist evaluation approaches in the future (Pawson & Tilley, 2004).

4) Scaling up of effective social innovations.

Although a critique of liaison/diversion schemes as a form of social innovation is that they not have been sufficiently evaluated before being scaled up, this has been the direction of movement in England and Wales, in the UK, following on from the government review

outlined in Bradley Report (2009). Hereby, the UK Government announced the National Diversion Programme with the vision of rolling out liaison and diversion services for all police custody suites and courts across England and Wales by 2014.

In this chapter, we explore in more detail the second of the above dimensions of social innovation, namely how the development of new solutions in response to these offender mental health can be achieved if articulated through the lens of interdisciplinary knowledge and coproduction.

INTEGRATED CODES AND NEW TERRAINS OF KNOWLEDGE

The way in which meaning is realised by any one professional or disciplinary group in any particular context may be described as a form of code (Beattie, 1995). It is how a discipline or professional group, for example, comes to understand their working environment and how they should behave within it. In the above case study, this code dictates how a lawyer is able to make sense of the court system in which s/he works, what it means to be a legal professional and their actions within this system as a result. 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. So psychiatrists treat mental illness in offenders based on the knowledge they have accumulated through their training and practice and the knowledge specific to that 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 lawyer 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.

This 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. anatomy), 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 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?

INHIBITORS AND FACILITATORS OF A NEW TERRAIN OF KNOWLEDGE

Beginning with inhibitors of new terrains of knowledge: 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, which gives the psychiatrist an element of power when interacting with the CJS. A barrier to collaborative practice, however, is if the psychiatrist fears that sharing their professional knowledge with CJS professionals 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 addressing offender mental health.

Maintaining power of this knowledge is perpetuated through professional education. Professional education is therefore 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. It is at this level of training that we have a chance to promote co-production of knowledge between disciplines and eventually social innovation

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.

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 ((Walsh, Gordon, Marshall, Wilson, & Hunt, 2005)(Wilhelmsson et al., 2012)(Orchard & Bainbridge, 2010)(Interprofessional Education Collaborative., 2011). 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 (Table 1). Currently these frameworks are developed within western environments and there is a need to validate these in wider clinical and global contexts. It is also important that these competencies do not get divorced from the context in which they are applied whether this be the clinical or geographical context. Collaborative capability rather than competence for social innovation may be most accurate in describing the ability to efficiently collaborate with other disciplines, therefore, and can be achieved through exposing learners to a wide variety of learning contexts to which to apply their growing competence as

a collaborative practitioner (Fraser & Greenhalgh, 2001).

TABLE 1 HERE

Central to all of these competencies/capabilities listed above is the acceptance that it is possible to understand something in more than one way or from more than one perspective. With this in mind we turn from a behaviourist focus on the outcomes or required skills and knowledge base required by a socially innovative workforce to constructivist approaches offering insight into how this may be achieved: transformational learning is one approach.

TRANSFORMATIONAL LEARNING

Mezirow (1997) maintains as humans we all have habits of mind, habitual ways of thinking, influenced by assumptions engrained into us through our cultural, social, educational, economic, political, or psychological experiences. These form a frame of reference that guides us when we interact with the world around us. To be able to access the knowledge of other disciplines and coproduce novel solutions to social problems, we need to be able to first recognise and reflect on our own personal and profession specific assumptions (subjective framing). This is then followed by an objective framing whereby the innovator sets up a dialogue with individuals from the other discipline to interrogate their assumptions (objective framing). Hereby learning for the individual occurs through, and with the purpose of, communicating with others. One can develop these discourse skills through alternately practicing various roles within this dialogue (e,g, being able to challenge a position, describe a position, defend a position). Finally, on having a view of one's own and the other discipline, the innovator moves to a final phase of reflecting, critiquing and weighing up the evidence for both sets of assumption, before creating a new world view that involves personal transformation and the building of a new terms of reference (Mezirow, 1997). It is in this synthesis that innovative solutions to problems lie.

Being able to engage in this type of discourse effectively means that learners wishing to cocreate knowledge have moved along a personal continuum of development. Clark (2006), for example, applies Perry's (1970) concepts of cognitive development to describe how health professionals may develop from being dualist in their perspectives, (assuming that theirs' is the only and the right perspective) along a continuum to an end point whereby they reach a

commitment to relativism phase where they are able to remain secure within their own professional identity, knowledge and skill, appreciate that of others and in combination see their unique contribution and fit within the wider team or system.

Similarly, Wackerhausen (2009) describes a further continuum whereby collaborators move from first order to second order reflection. In the former, the professional, whilst encountering problems in practice, responds by considering ways of circumventing the problem, removing the barrier or blockage to the current status quo. They subsequently revert to normal practice when the blockage is removed. For social innovation, however, second order reflection is required whereby new pathways are formed that respond to the problem by thinking beyond current practice and finding new ways of addressing these problems. So in the MHS/CJS, professionals who are first order reflectors, when faced with unacceptably high levels of mental illness in the offender population, may respond focusing on improving current delivery of mental health treatments delivered through prison in-reach or community mental health services and making these more accessible to offenders. Second order reflectors, however, will explore the design of an entirely new service, created through collaboration and shared leadership between the MHS and CJS. For these innovations to be sustainable and to grow, individuals within these services must be hold collaborative values, competencies and be transformational learners. Currently no training is available for the acquisition of these (Hean, Heaslip, Warr, and Staddon, 2011). There is a strong need for this training if diversion and liaison schemes are to be sustainable, innovative and if they are effectively to respond to the rapidly changing needs of the offender population.

COLLABORATION AT A SYSTEMS LEVEL

Up until this point, we have considered social innovation and coproduction between different disciplines as the transfer, sharing and coproduction of knowledge between individual professionals. Francis Westley offers a more systems level approach to social innovation, defining this as *" a complex process of introducing new products, processes or programs that profoundly change the basic routines, resource and authority flows or beliefs of the social system in which the innovation occurs. Such successful innovations have durability and broad impact…**social innovation strives to change the way a system operates**." p 2-3* (Westley, 2010)

He differentiates between social entrepreneurs (at the level of the individual), social enterprises (at the level of the organisation) and social innovation (at a system level). Although Westley's definition of social innovation lies at a macro level of analysis and omits the concepts of collaboration explicitly, he recognizes that social innovation requires a variety of actors working together. He also recognises that the action and impact of the social innovation is seldom governed by straightforward cause and effect relationships and that there is an element of opportunity that plays a role in these situations. As such his perspective on social innovation is in keeping with theories of second order activity systems and expansive learning that seeks to explore collaboration at a macro level of analysis between different systems and the components that make them (Engeström, 2001; Hean *et al.*, 2009).

Activity system theory, an evolution of socio cultural learning theory (Vygotsky, 1978). The basic tenet is that the meaning we make of an activity, or the learning that takes place during this activity, is a function not only of the individual's own cognition, ability or dedication. It is also mediated and influenced by factors external to the individual within the social world (Engeström, 2001). Professionals in the legal system (e.g. lawyers, judges, and probation officers) (Figure 1) and those in the mental health and related services (e.g. psychiatrists, community psychiatric nurses, psychologists) (Figure 2) in practice represent two separate activity systems that come together as social enterprises. The subject is the person within an agency undertaking a particular activity. The objective is the purpose of this activity. In the legal system (Figure 1), the subject is illustrated by a magistrate dealing with a mental ill defendant, who has been identified as having potential mental health issue. In the interest of the defendant, and to inform sentencing (the object), the magistrate requests an assessment and a report on the mental health of the defendant (the activity). In order to achieve this, the magistrate may complete a written assessment request or negotiate with legal advisors or liaison workers in court to make these requests. The latter are tools that mediate the activity. Surrounding this mediated activity is a range of other variables that may have influence. These include both the unwritten social norms and formal rules that govern the way in which the legal system function, e.g., government imposed targets that specify the times in which court cases need to be completed. Also surrounding the activity are members of the wider legal community who include defence lawyers, probation officers, court ushers, other magistrates, and security personnel. Each of these members may fulfil a particular role within the criminal justice system that will dictate how the activity under focus can be achieved (division of labour). There may be a range of contradictions within the activity system. For

example, there is a contradiction in the activity system (Figure 1) between the need to request a report (object) and governing rules that stipulate that court cases need to be completed in a set time frame. These time targets, and conflict with the time it takes for a report to be produced by the mental health services, means that the magistrate may decide it is not worth asking for a report as it delays proceedings.

FIGURE 1 HERE

In Figure 2 the subject is illustrated by a psychiatrist undertaking an assessment and making a report on a service user in contact with the criminal justice system. The psychiatrist does this using the assessment tools available to her/him as part of their normal practice. The way in which the report is written may be underpinned by several norms and rules, e.g.:

- psychiatrist's view that their first responsibility is to the defendant and his/her treatment (and not punishment)
- Patient confidentiality.
- In most places psychiatrists choose to complete reports for the court on a private consultancy basis over and above their current workload.

The community, which surrounds the report writing activity undertaken by the psychiatrist, includes other psychiatrists, community psychiatric nurses and social workers. A clear cut division of labour arises in report writing with psychiatrists being responsible for the full assessment and psychiatric reports required on the more seriously mentally ill or more serious offenders, (although, abbreviated health and social circumstance or screening reports are conducted by other health professionals in some areas). The outcomes of this activity can be challenging for the court in that information from the mental health service on a patient is not easily accessible and expectations of report content and timeframes are not clearly communicated (Hean, Warr, & Staddon, 2009).

FIGURE 2 HERE

In considering the collaborations required between the MHS and CJS to design socially innovative solutions to reduce mental illness in offenders, we need to look beyond the two

separate activity systems in isolation and review how the objects of each activity may be synchronized, how the systems overlap and together coproduce innovative solutions.

In practical terms, this may be achieved by what Engeström (2001) describes as a crossing boundary workshop, whereby individuals within each activity system are brought together in a facilitated environment (Figure 3). Together they are presented with a stimulus that mirrors dimensions of their collaborative practice. An example of such a workshop is reported in Hean et al., (2012). In this workshop a case study of a mentally ill offender served as this mirror. Agencies came together to co-observe the case study, identify challenges of working together within this collaborative context, discuss a potential solution to this problem and develop a model whereby, as a cross agency partnership, they might be able to address this. This is an exercise in combing regions of knowledge into new terrains of knowledge and new ways of working collaboratively is developed during these interactions.

Participants in crossing boundary workshops are particularly encouraged to explore the tensions or contradictions between the components of each system and to develop a joint model of collaborative working to address these challenges that is specific/bespoke to their locale. When a joint model is agreed, participants re-enter practice and test the model they have jointly developed, reconvening in subsequent workshops for an evaluation of how the co constructed model is working.

Professionals from both the MHS and CJS learn with, from and about each other during these events, but the learning that takes place in these environments is unpredictable and opportunistic (Engeström, 2001). The social innovations that arise from the crossing boundary workshops will be complex and it is unlikely that these will be understood in simple mechanistic/linear ways. There must be an acceptance by workshop facilitators that the coproduction that arises during these events may not always be effectively engineered (Cooper and Geyer, 2008)(Westley, 2010). There should also be recognition that the learning and coproduction taking place is not always a comfortable place to be and that expecting professionals from different systems to work together may threaten the social cohesion of each participating professions (Hammick 1998) if due care is not taken by workshop facilitators. This disruption is common in social innovation generally (Westley, 2010) and those engaged and acting upon second order reflection more widely (Wackerhausen, 2009).

FIGURE 3 HERE

CONCLUSION

The public sector needs to be ready for social innovation to address the increasingly complex social needs of the population. To be ready they must explore the processes of knowledge coproduction between interdisciplinary actors from different professions and organisations and how to prepare the workforce to engage in this process. Conditions must be put in place that foster an environment in which different actors within the public sector are sufficiently comfortable to share and coproduce new knowledge. Further, public sector workers should be able to demonstrate collaborative practice capabilities/competencies and values that will allow them to cross disciplinary boundaries. They need to become life long transformational learners capable of second order reflection and a commitment to relativism. Individuals do not work in isolation however and a systems approach to social innovation is also required. Engestrom's activity theory is particularly useful in articulating such an approach. The use of crossing boundary workshops and then learning skills of interdisciplinary discourse are practical ways in which coproduction and social innovation may be achieved.

REFERENCES

Beattie A. 1995. War and peace among the health tribes. In: Soothill K, Mackay L, Webb C, editors. Interprofessional relations in health care. London: Edward Arnold. pp 11–30.

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

Bradley, Lord. (2009). The Bradley Report. London: Department of Health.

Christmas, S., & Millward, L. (2011). New medical professionalism, London: Health Foundation.

Clark, P. G.. (2006). What would a theory of interprofessional education look like? Some suggestions for developing a theoretical framework for teamwork training Journal of Interprofessional Care, 20(6), 577–589.

Cooper, H., & Geyer, R. (2008). Using "complexity" for improving educational research in health care. Social Science & Medicine, 67(1), 177–182.

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

Engestrom Y. (2001). Expansive learning at work: towards an activity theoretical reconceptualisation. Journal of Education and Work, 14, 133–156.

European Commission. (2013). Guide to social innovation. Brussels: EU Commission

Fraser, S. W., & Greenhalgh, T. (2001). Coping with complexity: educating for capability. British Medical Journal, 323(7316), 799–803.

Frenk, J, Chen, L, Bhutta, Z a, Cohen, J, Crisp, N, Evans, T, Fineberg, H, Garcia, P, Ke, Y, Kelley, P, Kistnasamy, B, Meleis, A, Naylor, D, Pablos-Mendez, A, Reddy, S, Scrimshaw, S, Sepulveda, J, Serwadda, D & Zurayk, H 2010, Health professionals for a new century: transforming education to strengthen health systems in an interdependent world.,Lancet, vol. 376, no. 9756, pp. 1923–58

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

Hean, S., Heaslip, V., Warr, J., & Staddon, S. (2011). Exploring the potential for joint training between legal professionals in the criminal justice system and health and social care professionals in the mental-health services. Journal of Interprofessional Care, 25(3), 196–202.

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., Warr, J., & Stadon. S. (2009). Final report evaluation of the south west mental Offender Health South West. Bournemouth: Bournemouth University and SW Offender Health.

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.

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

Landry, R., Amara, N., & Lamari, M. (2002). Does social capital determine innovation? To what extent? Technological Forecasting and Social Change, 69(7), 681–701.

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

Sainsburys Foundation (2009) Mentally ill offenders need more jail diversion schemes (2009). Community Care, (1759), 10.

Mezirow, J. (1997). Transformative Learning: Theory to Practice. New Directions for Adult and Continuing Education, 1997(74), 5–12.

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

Pawson, R., & Tilley, N. (1997). Realist Evaluation London: Sage.

Perry, W. G. (1970). Forms of intellectual and ethical development in the college years: A scheme. New York: Holt,

Vygotsky, L. (1978). Mind in Society. Cambridge.: Harvard University Press.

Wackerhausen, S. (2009). Collaboration , professional identity and reflection across boundaries. Journal of Interprofessional Care, 23, 455–473.

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.

Westley, F. (2010). Making a Difference Strategies for Scaling Social Innovation for Greater Impact, PhD Candidate in Planning, 15(2), 1–19.

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.

World Health Organisation. (2005). Mental health and prisons: information sheet, 1–6. Geneva: WHO