

Title:

Using social innovation as a theoretical framework to guide future thinking on facilitating collaboration between mental health and criminal justice services.

ABSTRACT

Offender mental health is a major societal challenge. Improved collaboration between mental health and criminal justice services is required to address these challenges. This paper explores the potential social innovation as a concept that offers an alternative perspective on collaborations between these services and a framework to develop theoretically informed strategies to optimize interorganizational working. Two key innovation frameworks are applied to the offender mental health field and practice illustrations provided of where new innovations in collaboration, and specifically cocreation between the mental health system and criminal justice system, take place. The paper recommends the development of a competency framework for leaders and front line staff in the mental health system and criminal justice systems to raise awareness and skills in the innovation process, especially through cocreation across professional and organizational boundaries.

Key words: Mental health, criminal justice, social innovation, collaboration, integration

Background

Mental illness is higher in the offender population than the general population average, representing an area of severe health inequality. This is confirmed in a meta-analysis of 23 000 prisoners in 12 Western countries reporting psychosis in 4% of prisoners, compared to 1% in the general population, major depression in 10–12% (compared to 2-7%), and personality disorder in 42–65% (compared to 5-10-%) (Fazel & Baillargeon, 2011; Fazel & Danesh, 2002). Bradley, (2009) raises concerns, therefore, of the equivalence of offender mental health services if compared to services offered to the wider population.

It is acknowledged that professionals from both mental health and criminal justice systems need to work together to address the needs of the mentally ill offender population (Hean, Warr, & Staddon, 2009; Strype, Gundhus, Egge, & Ødegård, 2014; World Health Organization, 2005). This is reflected in the United States (US) Congress of the Justice and Mental Health Collaboration Program authorised by the US Congress in the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). This program aims explicitly to improve the mental illnesses of offenders through facilitating collaboration among the criminal justice, mental health treatment and substance abuse services (CSR Incorporated, 2012).

Mental health and criminal justice staff cross professional and organizational boundaries when working together. Ideally this should occur in such a way that staff from both services gain collaborative advantage (Vangen & Huxham, 2013). In fields such as physical health, collaborative advantage is linked to reduced length of patient hospital stay, lower costs, improvement in the way drugs are prescribed and increased audit activity (Zwarenstein, Goldman, & Reeves, 2009). The collaborative advantages gained by the criminal justice systems and health care working together are less well understood although it is clear that the overlap of these two systems creates a complex adaptive environment where many elements interact with each other in often non linear and unpredictable ways (Cilliers 1998). Knowledge transfer between systems is often problematic and the assumptions and values that guide behaviour within each system differ (Hean et al., 2009). This is illustrated by the alternative perspectives held by different actors on the management of risk versus rehabilitation when working with offenders or differing views on what constitutes offender confidentiality and appropriate information sharing (Lennox, Mason, McDonnell, Shaw & Senior, 2012).

But this diversity in perspectives also promises the development of *socially innovative solutions* to address offender mental health. Service leaders must be responsive to the rapidly changing needs of the offender population, the increasing complexity and specialization in their care and rapidly advancing technologies (both in health treatment but also organizational design and coordination). New interventions are constantly required and organizations must combine forces to develop ways of working that are cost effective and deploy resources differently and effectively. However, innovation as a concept is often used uncritically to describe any new idea or intervention and little attention is given explicitly to improving cross organizational or professional partnerships that foster this.

Aim

In this paper we explore the concept of social innovation and its underpinning theoretical frameworks in greater detail, discussing how it may be applied to the offender mental health field. We pay particular attention to the role of interorganizational collaboration in this process.

Social innovation, as a clearly defined, multidimensional construct, offers a new and important perspective that can contribute to the development of improved ways of assuring that offenders receive equivalent, appropriate mental health treatment and support. To illustrate its potential we take two key frameworks within the broader innovation more commercially driven literature and apply these to some exemplar social innovations at the interface of mental health system and criminal justice system. We then suggest ways forward on how social innovation may be encouraged in the collaborations that occur across between these systems.

An ecosystem for innovation and cocreation

Social innovation is both the process and outcome of taking new knowledge or combining existing knowledge in new ways or applying it to new contexts. It is primarily about creating positive social change, and improving social relations and collaborations to address a social demand (European Commission, 2013). The defining characteristic of social innovation is its emphasis on public value and social need (Hartley, 2005). The ecosystem for innovation model (Bason, 2010) sets out four key and interdependent dimensions required for social innovation that applied to the offender health are:

- *Consciousness*: The degree to which organizational leaders in the mental health and criminal justice systems (leaders and front line staff alike) are aware of the concept of innovation and consciously strive towards achieving this when developing new interventions that better address the needs of the mentally ill offender population.
- *Capacity*: The degree to which structures within organizations allow social innovation to take place. For example, how governance, guidelines and training, can support prison officers and prison governors reflect on and implement new ways of working with inmates in their care.

- *Cocreation*: The collaborative processes that allow the cross fertilization of ideas to occur between both health and security perspectives and which are necessary for innovative ideas to develop.
- *Courage*: the leadership environment required to facilitate the above dimensions (Bason, 2010).

In other words, mental health and criminal justice system professionals need to be aware of their roles as social innovators, implementing and expanding on new ideas within their own organizations and across systems. They need an awareness of the structures and leadership skills that should be set in place that facilitate innovation in these two systems and the nature of cocreation that may take place between systems. But how to achieve this is not yet understood. This paper aims to contribute to this understanding in the mental health/criminal justice milieu by exploring one of Bason's dimensions listed above in more detail, namely that of *cocreation*.

Concepts of cocreation

Cocreation describes the positive joint activity between two or more interdependent actors that leads to outputs with added public value (Alford, 2009). Not all interorganizational activity requires cocreation activity however. For example, leaders in the criminal justice system may wish to develop mental health assessment in house, training police officers, prison wardens etc. to better recognize and deal with offender mental health issues. This may take the form of training in mental health awareness for example. Because it is provided in house, only internal resources are required. Alternatively, they may transport inmates to psychiatric hospitals for assessment or bring psychiatrists to the prison from local health services on regular intervals. This relies on external source only to deliver the service. These two activities are qualitatively different from mental health and criminal justice professionals collaborating actively together to create joint protocols or knowledge systems where their respective knowledge bases are actively combined (cocreation). These products have added value to working alone in organizational silos but the benefits must outweigh the resource expended to achieve these (time, human, financial etc.).

Cocreation can occur at a micro or macro level. Cocreation at the micro level is illustrated through the small scale collaboration described by Roskes & Feldman (1999) between a forensic psychiatrist in a US community based mental health treatment program and a probation officer of the federal prison system. To address the lack of treatment compliance in recently released mentally ill offenders, these two professionals cocreated a new working protocol whereby the probation officer agreed to routinely refer paroled offenders to the community health center. Scheduled regular contact between professionals and feedback to the probation officer on the offender's treatment plan, attendance and

progress were also included in the protocol. All offenders on probation were made aware of the frequent contact between the clinician and probation officer. This joint activity was evaluated and was shown to increase offender treatment compliance and improve mental health outcomes (Roskes & Feldman, 1999).

Cocreation at a macro level takes the form of organizational models designed to promote collaboration across organizational boundaries. This is illustrated in the coordination of Local Crime Preventive enterprises (CLCP), a Norwegian initiative targeting youth delinquents and aimed at preventing new and renewed criminal activity. These enterprises brought together police and professionals in schools, social welfare and health services (including mental health) in steering and working committees at a local level with an appointed CLCP coordinator responsible for the information flow between levels (Strype et al., 2014).

The relationships and protocols described at both these micro and macro level represent new ways of working, new social relationships with social value for the offender and general public. As such, they both demonstrate elements of social innovation. The professional and service relationships developed are both the process and the product of cocreation activity. Increased treatment compliance, reduced recidivism, and primary prevention of criminal activity outweigh the costs of freeing time and resource for services and professionals to come together to collaborate. Direct contact between professionals allowed them to synthesise their distinct knowledge bases and develop innovative ways of managing interorganizational working unique to their needs. This overlap of distinct sources of knowledge is crucial in fostering innovation. It constitutes large stocks of social capital (the accumulative gain from membership of a social network) but it often originates from a disorderly interaction between a diverse set of actors (Bourdieu, 1997; Landry, Amara, & Lamari, 2002; Vangen & Huxham, 2013). These disorderly interactions can challenge service leaders who should then consider the leadership style and organizational structures they must adopt to optimise collaborative relations. More on leadership for collaboration and the relationship between organizational structures and collaborative relations can be found in Willumsen (2006) and Willumsen, Ahgren & Ødegård (2012).

Four dimensions of innovation

Bason's (2010) framework above helps us understand the importance of raising awareness of social innovation, the importance of putting structures and leaders in place that support social innovation and emphasises the role of cocreation in the social innovation process. A second social innovation framework, a four dimensional model of social innovation (European Commission, 2013), offers a complementary perspective, one that describes innovation in terms of four key dimensions, namely:

- 1) *Identification of new/unmet/inadequately met social needs*
- 2) *Development of new solutions in response to these social needs*
- 3) *Evaluation of the effectiveness of new solutions in meeting social needs*
- 4) *Implementing and scaling up of effective social innovations.*

Identification of new/unmet/inadequately met social needs, including high mental illness in the offender population, is well established in the literature (e.g., Fazel & Baillargeon, 2011; Fazel & Danesh, 2002), so we focus here on the remaining three dimensions (2-4) within the model.

Development of new solutions in response to the social needs of mentally ill offenders

Any intervention designed to improve collaborative working between the mental health and criminal justice systems will vary from country to country dependent on the way the two systems are configured nationally. These will vary regionally and locally even within a single nation state. It is therefore not our intention in this paper to suggest what these future innovations will be, as these must come from those working at the front line of the mental health-criminal justice interface and be context specific. We can suggest some areas where innovation is required.

Consider prisoner rehabilitation and application of the risk, needs responsivity (RNR) model to mentally ill offenders for example (Skeem and Petersen, 2011; Andrews & Bonta, 2007). In this model of crime prevention and rehabilitation, criminal justice (e.g. prison officers), health and welfare services (e.g. mental health therapists) work closely to apply the risk-needs principle. This posits that criminal behaviour is predictable and resources for offender rehabilitation should be directed primarily at offenders with the highest risk of reoffending. Risk is assessed in terms of static factors that cannot be changed (e.g. gender) and little can be done about these factors. However, dynamic features of the individual (such as substance abuse and antisocial personality patterns) can be changed through therapeutic interventions that focus on these latter needs. Skeem and Petersen (2011), in a review of factors that affect recidivism in mentally ill offenders, conclude that a direct link between mental illness and recidivism may only be true for a very small number of mentally ill offenders. They suggest that other criminogenic risk factors may be similarly, if not more, predictive of reoffending in this population group and recommend that mental health treatment be complemented with interventions that address these wider needs. The four most predictive risks factors (Andrews and Bonta, 2010) are a history of previous criminal activity, antisocial personality pattern, antisocial cognition and antisocial associates. Substance misuse (see Telpin, 1994), poor family relations, lack of engagement in positive leisure activity and gainful employment/schooling are other important although less influential risk factors. This means that criminal justice and mental health organizations must work with a diverse and complex set of professions and organizations to

address offender needs holistically: psychiatrists address the medical treatment of mental health needs, but psychologists deliver cognitive behavioral therapies and motivational interviewing to address antisocial cognitions; substance misuse organizations work with alcohol or drug addiction and social workers, and a range of not-for-profit and public sector organizations, are involved in rebuilding family networks or linking offenders with employment, training or prosocial leisure opportunities. At a front line level, they work together to create unique solutions for each individual offender. At strategic levels they can work towards developing new ways of managing interorganizational working.

In both instances professionals may need to overcome logistical and resource issues to meet together and conflict or poor communication may arise when the world views of the different organizations and professions overlap especially if the need for mental health treatment does not feature directly in assessment of the eight main risk factors for recidivism. Treatment is still essential because of the indirect impact on how offenders respond to interventions that address the eight main risk factors, as well as issues unrelated to risk such as cost to the health system and offender wellbeing (Skeem and Petersen 2011). The potential for poor communication is illustrated in a comparison of the different assessment tools used by mental health and criminal justice systems when evaluating risk: health systems in England employ the Health of the Nation Outcome Survey (HoNOS) (Wing, Curtis, & Beevor, 1994) and prison and probation services employ an Offender Assessment System (OASYS) assessment tool. With the different systems using different tools, there is potential for the same offender to be assessed very differently by each system, leading to service contradictions, duplications and lack of continuity in care. Social innovators need to find new solutions to this problem. These may involve the formation of joint risk assessment tools, for example, where professionals from mental health, criminal justice as well as information technology are brought together to cocreate a solution that accounts for all professional priorities. The tool itself could promote cocreation and be not simply a tool where knowledge from health and criminal justice is transferred uncritically. Innovators should think of ways in which profession-specific speak is translated into common language and the mechanisms or structures that could be introduced to allow all knowledge bases to be combined and transformed into a joint decision about the needs and risk associated with the offender (see Carlile, 2004 for further discussion on boundary crossing).

Evaluation of the effectiveness of new solutions in meeting social needs

The development of innovative ways of collaborative working does not always lead to better outcomes. A third key dimension of social innovation, the evaluation of the effectiveness of the proposed change, is essential. Evaluators of interventions implemented at the interface of the criminal and mental health systems currently focus primarily on patient/offender outcomes (including

reoffending rates and mental health outcomes). Evaluations specifically of the quality and quantity of collaboration and cocreation activity between professionals or services are largely absent. The actual and optimum level of structural integration between the mental health and criminal justice systems remains unmeasured although Ahgren & Axelsson, (2005) would suggest that the optimum level of integration will vary from context to context and one type of offender to another. Similarly little is known of the relationship between structural integration and level of cocreation and when and where cocreation 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.

Implementation and scaling up of effective social innovations.

The fourth dimension of social innovation is the need to implement, disseminate and scale up positively evaluated interventions. Service leaders need clear strategies with which to spread good practice, adapt and adopt innovations to different contexts (Hartley, 2005). We illustrate the importance of implementation and scaling up in the examples below:

Rehabilitation of the offender begins in prison where prisoners may engage in addiction and mental health programs in a controlled environment. Alternatively, offenders, serving community based sentences, receive support under the supervision of probation. But the offender must be able to access this support upon release or when the probation period has been completed. They will need extra support to attend these services when the structures placed upon them in prison, or under probation, are no longer in place. Criminal justice and mental health professionals work closely and in partnership with the offender in future planning to ensure the offender has a support network in the community that will help continue their treatment upon release. The criminal justice services need to collaborate with external services not only to ensure that mental health services are available outside of the prison in the offenders home location but also that conditions that are in place that make it more likely that the offender will comply with treatment (i.e. attend medical appointments etc). Suitable housing or employment support must be in place, for example.

Two approaches to addressing this problem are presented first in the Norwegian Import model and second in the US Full Service Partnership model. In the Norwegian, import model, health professionals in the prison are recruited from and work in adult services available to the wider population. They are hence well placed to ensure the offender has access to a similar standard of service to the general population as well as providing some continuity of service when the offender is released (Norwegian Ministry of Justice and the Police, 2008). The US Full Service Partnerships provide an alternative model. These are intensive outpatient programs based on the Assertive

Community Treatment model. These are community based and integrate housing, employment, education and health support for individuals with co-occurring mental health, substance abuse disorders, homelessness and incarceration histories. Although clients receive a wide range of services, and entry to emergency care is reduced, these intensive programs are expensive to run in relation to the benefit they produce (Starks, 2012).

Both the import model and the full service partnerships were social innovations in their day, new solutions to practice based problems. However, neither can be viewed as innovations if all four dimensions of social innovation are not accounted for. Looked at from this perspective, social innovators must not only consider the evaluation of the outcomes of these models, but also the processes by which these are implemented and scaled up regionally. Barriers to implementation are particularly important to address, as no matter the creativity of the proposed model, these are worthless if implementation is unsuccessful. In both the import model and full service partnerships, a key barrier to implementation is the level of community service provision. The patchy provision of lower level more generalized mental health treatment in the community, increasing responsibility for community services to receive people leaving all institutions (not only prisons) with no extra or reducing budgets, means that interagency working and the implementation of these innovative solutions to offender rehabilitation is a challenge. It could be argued, however, that it is just this type of pressure that may well drive future innovation in this area as community and secondary services struggle to find quality and cost effective solutions to these pressures.

A further critique of many reports of cocreation activity between mental health and criminal justice systems is the small-scale nature of the interventions developed. One off or locally based interventions are most often described (e.g. Roskes and Feldman, 1999) with no evidence of the success of the interventions being disseminated or consideration being given on how this might be practically implemented into wider practice. These smaller interventions should not be dismissed however, as these represent areas of bricolage, a concept used by Fuglsang (2010) that is distinct from managerially lead more radical innovation. It captures the tinkering or small adaptive processes or innovations whereby professionals on the ground adjust given protocols or pressures in small incremental ways to improve their practice.

There are some exceptions to the lack of scaling up of small innovations within mental health and criminal justice. Strype et al.'s, (2014) description of the CLCP enterprises is one example. Two further examples described here are the Crisis intervention teams in the US and diversion and liaison schemes in the United Kingdom (UK).

Crisis Intervention Teams

These are diversion schemes created through a partnership between the criminal justice system, behavioral health systems, and the advocacy community. Specialized police officers are trained to recognize mental health issues and are then deployed to deescalate 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, US where a young man with schizophrenia in crisis, attacked and was killed by police officers. 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 innovative 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 (Vickers, 2000). Together they developed training and deployment of specialized police officers in mental health issues and the community resources they may call upon that relate to mental health. Police officers are able to recognize mental health issues in individuals, are skilled in deescalating crisis events and have the knowledge of which community and other resources to refer individuals to for treatment. Evaluations of the model are associated with reduced arrest rates, reduced injuries to police and subjects and fewer jail suicides. (Tucker, Mendez, Browning, Van Hasselt, & Palmer, 2012). The dissemination (see for example <http://www.cit.memphis.edu/>) and scale up of this model is clearly evident in its spread to other geographical locations within the US (e.g., Cross Brown, Mulvey, Schubert, Griffin, Filone, Winckworth-Prejsnar, Dematteo, & Heilbrun, 2014) as well as into other care contexts (e.g., jail settings -Tucker et al., 2012).

The Crisis intervention team intervention is a clear example of social innovation bearing the characteristics of cocreation between mental health and criminal justice systems and the four dimensions of problem identification, solution, evaluation and dissemination/scaling up put forward by Bason (2009) and the European Commission (2013). Little is written however, on the actual processes by which these innovative programs are implemented in practice (Hartley, 2005).

Diversion and liaison schemes

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 roll out of liaison and diversion services for all police custody suites and courts across England and Wales by 2014. These services are characterised by mental health workers being physically located within the criminal justice system with the remit of diverting offenders with severe mental health problems away from prison and into mental health

services. The schemes provide screening and mental health assessment for offenders in court and custody suites and facilitate information flow to and from police, prosecutors, probation, magistrates etc. and provide relevant signposting to health and social care services when appropriate (Clapper, 2012). The anticipated outcomes of these schemes include reduced court delays leading to fewer adjournments, an increase in the screening of mental health issues in this population and better defendants support.

In social innovation terms, the designing of these schemes is a novel solution that addresses an identified population need. A new service design was created in this example that fosters new relationships between police, lawyers, judges, and ushers in the criminal justice system on the one hand and with mental health nurses, psychiatrists, psychologists and social workers in the mental health services on the other. Previously these professionals have been geographically and organizationally separated from each other (Hean et al., 2009). Evaluation is essential but it is reported currently that this is hampered by poor or consistent record keeping in these services and low sample numbers. Evaluators have reported an increase in time between release and reoffending for individuals accessing these services and improved mental health outcomes, however (Haines, Goldson, Haycox, Houten, Lane, McGuire, Nathan, Perkins, Richards & Whittington, 2012). There is a lack of explicit guidance on actual implementation of these schemes, but scaling up of what were initially small scale initiatives, into a National Diversion, fulfills the final dimension of a social innovation.

The social innovation framework provides us with a tool with which to critique the above interventions. It guides our attention, for example, to a need to address implementation issues and for leaders to create locally relevant collaborations between the court and mental health professionals working within this. From the cocreation perspective, it is not clear how these schemes promote cocreation between the different professionals or if activity is only about a simple transfer of knowledge between services. Knowledge transfer may be all that is required but if so, these are unlikely to be zones of future innovation and they may be unlikely to respond to any changes in future service needs.

Further barriers and facilitators of cocreation and social innovation

Organizations wishing to encourage social innovation and cocreation will face challenges, some of which have been already touched upon. A tradition of working in uniprofessional silos and power imbalances are further factors that work against these processes. Innovation and cocreation hinge on

cultural diversity, but the flow of information and resources between partners may be blocked if they fail to understand each other's world view. A tension hence exists between the complexity that culturally diverse interactions introduce versus the need for our working lives to be as simple as possible (Vangen & Huxham, 2013). Organizations may strive to simplify collaborations by collaborating only with those organizations similar to them in terms of philosophy and working practices (e.g. mental health with mental health). They may alternatively try to dominate the collaborations in order to impose their working framework or agenda on other collaborators. In both cases they are at risk of then not fully benefiting from the diversity provided by other working 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 many reentry interventions are developed in collaboration with mental health services, the majority are led by the criminal justice system. The reasons for the criminal justice system taking the majority of responsibility for the mental health of the prison population in this case is unclear. Taken from Vangen and Huxham's perspective, however, one may hypothesise that the criminal justice system manages the complexity of dealing with the very different mental health service culture by unconsciously dominating mental health strategies for offenders. However, the impact of this is that the mental health perspective and priorities are not accounted for, or underrepresented, and opportunities are lost for truly innovative reentry services to be cocreated by both systems.

The optimum lies in a balance of complexity versus simplicity. Perhaps in successful interactions, such as between the probation officer and the psychiatrist mentioned earlier, the balance has been found: their professional backgrounds are sufficiently different for innovation but sufficiently similar for communication and common ground to be achieved. However, 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. This was developed and managed through regular multidisciplinary team meetings between prison wardens, mental health and other relevant professionals. Together they decide whether to transfer prisoners from cells into the unit. They then work together, and with the offender, to develop individualized care plans. The evaluation of this unit suggested this collaboration had been positive and beneficial, reporting reduction in unmet emotional need of offenders, a decrease in high risk behaviours, an improvement in peer relationships and engagement with the regime (Ryan & Mitchell, 2011).

It is not our intention to review all the factors that challenge collaborative working and we refer readers to reviews by Warmington, Daniels, Edwards, Brown, Leadbetter, Martin & Middleton (2004) and Atkinson, Wilkin, Stott, Doherty & Kinder (2002) for a comprehensive list of potential challenges.

However although these will have some traction in any environment generically, it is important to note that finding ways to collaborate and developing structures that facilitate collaboration is a social innovation itself. As such, solutions must be developed by practitioners themselves, using the dimensions of social innovation described above, and not by external researchers or consultants. We offer below, however, some thoughts on training models that can facilitate how practitioners develop context specific solutions to practice problems, whether this be ways of collaborating or the wider problem of addressing offender needs.

The way forward: promoting innovation at the interface of the mental health and criminal justice system

Social innovation as a concept has much to offer those looking to find new ways of addressing the challenges of mental health in the offender population. This perspective focuses the service leader's attention on the importance of cocreation rather than knowledge transfer, the need to explicitly identify the problem to be resolved and to think of ways in which innovative solutions can be cocreated in partnerships across the two systems rather than in organizational isolation. Innovations need to be routinely evaluated and finally clear dissemination, implementation and scaling up strategies must be developed of innovations found to be most effective. However, in much of the literature describing collaboration between mental health and criminal justice systems there is a notable lack of articulation of these interventions as being innovations or of attention being paid to the processes of cocreation, scaling up and implementation. Therefore, as Bason (2010) suggests, service leaders, as a first step towards encouraging innovation between mental health and criminal justice, should promote awareness of the meaning of the concept and its dimensions both at a practice and leadership level. Training should highlight some of the factor described in this paper: the utility of social innovation as a concept, develop an awareness of what it means to be social innovative, of the benefits and processes that encourage or detract from successful collaborations required to achieve social innovation across organizational boundaries. Training needs to go beyond mental health awareness training for prison professionals (even if delivered by mental health professionals) where knowledge from one system is uncritically transferred to professionals in the other. Training must develop an explicit emphasis on criminal justice and mental health professionals actively working together to cocreate new solutions to practice problems, working together to learn with and about each other (Hean 2015). It should develop what Darsø, (2012) describes as innovation competencies, those skills and knowledge required for leaders and front line staff to be collaborative and innovative in their professional practice. Although a multidimensional framework would be anticipated, a key domain is the capability to cocreate across organizational borders.

The development of such a framework is currently underway in a EU funded study exploring the development of a pedagogical framework supporting training for collaborative practice between the criminal justice systems and mental health systems with the ultimate goal of improving the mental health of the offender population (<http://cordis.europa.eu/project/rcn/188119en.html>). This builds on a model of collaborative training for the mental health and criminal justice systems based on Engeström's crossing boundary workshops (Hean, Staddon, Clapper, Fenge, Jack, & Heaslip, 2012). Facilitators of these workshops help professionals explore each others' mindsets and give them space to cocreate innovative solutions to the challenge of offender health, shared across the mental health and criminal justice systems. Workshops draw on Engeström's activity system triangles to articulate theoretically the components of each system 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 of participants' experiences of working between mental health and criminal justice. This stimulates a discussion in which contradictions are identified and joint solutions cocreated. Participants return to practice to test out their 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 cocreation can be raised for mental health and criminal justice services but more importantly it gives them space (geographical and time related) to cocreate together in a carefully facilitated environment. These workshops can be used both as vehicles for the implementation of innovation from a top down perspective or alternatively for the identification of emerging problems in collaborative practice by professionals themselves. Mental health and criminal justice leaders can come together to develop formalised innovative projects to respond to policy directives or frontline professionals can share their every day collaboration needs and share personal experiences of how these may have been resolved or how policy and managerial directives may be adapted to their individual context and patients.

The above workshop model has much in common with cross training workshop models in the US in which the sequential intercept model is used along side cross systems mapping to improve collaborative relationships between the criminal justice system and other services including mental health and substance misuse centers (Vogel, Noether & Steadman, 2007). The Sequential Intercept model (Munetz & Griffin, 2006) originates from a concern that people with mental illness, who often come in contact with the criminal justice system, should not be criminalized and instead be diverted away from the criminal justice system. The model identifies five main intercept points where this diversion should take place: namely pre-arrest when the individual is in crisis and law enforcement and emergency services are likely to be involved; at the point of arrest, during court appearances,

upon release from prison back into the community and lastly when the offender is under supervision in the community (probation for example). The cross training workshops bring representatives from prison, mental health, substance misuse and others together in workshops aimed at improving collaboration between these services. Workshops include systems mapping exercises that identify the services through which an offender passes at the different intercept point identified in the model. Workshops also develop an action plan in which the representatives commit to a strategic plan addressing small short term wins to be implemented by participants in partnership back in the workplace. Technical assistance is provided after the completion of the workshop to facilitate the operationalization of these plans.

These cross training events share much in common with the crossing boundary workshops, both aiming to bring together representatives from different systems to work together, identifying potential contradictions in their overlapping systems and developing an agreed action plan to be taken into practice and reevaluated. The cross training workshop of Vogel et al. (2007) has the advantage of being validated within the mental health/criminal justice field, particularly in relation to its incorporation of the sequential intercept model, focusing attention of identified key participants on particular problem areas where collaboration and innovation is important. Its inclusion of systems mapping and the detail of the nature of the action plan to be drawn up are added advantages. The advantage of the Engeström's crossing boundary workshop is the contribution it makes through its focus on the processes of emergent learning that takes place during workshops and the activity system theoretical models that underpin these workshops and that allows participants a holistic view of the overlapping systems being brought together during the workshop. It is our intention in our current work to combine the advantages of both these workshop models within an European context.

CONCLUSION

Collaboration across mental health and criminal justice systems is challenging but this paper suggests that, when looking to the development of improved ways to address the needs of mentally ill offenders, a social innovation lens offers service leaders from the criminal justice and mental health services a cognitive tool with which to critique current and future collaborative interventions. We applied this perspective to some examples of where the two systems work together and find that these interventions are seldom described as innovations, that the evaluation of the cocreation element of these collaboration activities are absent and that descriptions of the interventions tend to overlook implementation and scaling up strategies. The development of an operationable innovation competence framework to underpin training and quality improvement is recommended specifically as a means of raising awareness of the concept and promoting social innovation by mental health and criminal justice leaders and front line professionals alike, to develop their the capability to be socially

innovative in their practice and leadership and to cocreate new solutions to the long standing problem of offender mental health.

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