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Chapter 14

Training to improve collaborative practice: a key component of strategy to reduce mental ill health in the offender population

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Sarah Hean, Elizabeth Walsh, Marilyn Hammick

Introduction

Internationally there are unacceptably high numbers of people in contact with the criminal justice system (e.g. in police custody, in court, in prison) who have mental health issues (Fazel & Danesh, 2002). Addressing mental health in the offender population is essential to maintain public safety, improve the wellbeing of the offender and their family, reduce reoffending and the impact of this on the public purse. Poor interagency and interprofessional working have been highlighted as key factors that have severely compromised patient and public safety in the past: working at the interface of the mental health services and criminal justice systems has been shown to be particularly challenging with complex communication and information sharing strategies being required. A key aspect of improving joint working is the delivery of a continuous or integrated rehabilitation pathway characterized by early diagnosis, treatment, appropriate sentencing or diversion of people away from the criminal justice system and into mental health services (see Rogers and Ormston this volume). Integrated, effective partnership working is required between these two systems. Training and development to assist and support staff involved in this team working endeavour is essential. Within the mental

health/criminal justice arena the Bradley Report (Bradley, 2009) in the UK calls for joint training between agencies. To date there is little that suggests the content or format this training should take.

This chapter responds to this shortfall by exploring how the enhancement of collaborative practice between mental health services (MHS) and the Criminal Justice System (CJS) can be seen as one element of the armory necessary to combat the issues posed by mental illness in the offender population (Durcan, Saunders, Gadsbuy and Hazard, 2014). We explore why collaborative practice between different professionals and agencies is high on the agenda globally (World Health Organisation, 2010) and why professionals within the MHS and CJS need to be trained to be able to work collaboratively in the interest of reducing mental ill health in the offender population. Although training of this type is largely absent in this area, we explore potential approaches to training focusing on both a systems and interpersonal level of analysis, giving some of examples of interprofessional training used in the MHS and CJS context to illustrate these approaches. A triple phase model of collaborative practice training for professionals within the MHS and CJS is proposed.

Offender mental ill health is a major societal challenge. Globally, there are unacceptably high numbers of people in contact with CJS who have mental health issues with 7-9 out of 10 prisoners demonstrating signs of at least one mental disorder (Fazel & Baillargeon, 2011). This is far higher than the average population level of mental illness and as such represents an area of severe health inequality. A meta-analysis of 62 surveys of 23 000 prisoners in 12 Western countries, for

example, showed the prevalence of psychosis to be around 4%, compared to 1% in the general population, major depression 10–12% compared to 2-7% in the general population, and personality disorder 42–65% compared to 5-10-% in the general population (Fazel & Baillargeon, 2011; Fazel & Danesh, 2002). When offender mental health is not addressed, this leads to a deterioration of the mental disorder (Nurse, Woodcock, & Ormsby, 2003; see Gobbels, Thakker and Ward this volume). In turn this impacts on offender wellbeing as well as their failure to adjust to community life on release, resulting in their social exclusion and increasing the likelihood of reoffending (World Health Organisation, 2005). Offender mental ill health also effects wellbeing of the offender's family, fellow prisoners, frontline police/court/prison staff and public safety. Further, the CJS, if uninformed, can impose inappropriate sentences on offenders and as mentally ill offenders are likely to reoffend, this places an economic strain on the public purse and prison and mental health hospital places (World Health Organisation, 2005).

Multi-agency training has been tried before, but often in a piecemeal fashion and usually as part of a local initiative to respond to identified cross-agency needs in mental health support (see Pakes & Winstone, 2009; Bradley, 2009; Durcan et al., 2014). This chapter focuses on the importance of collaborative practice between the MHS and CJS as a key factor in work to address the issues posed by mental illness in the offender population. We then explore the vital role of inter (rather than multi)-agency training for MHS and CJS practitioners to enable them to work collaboratively in the interest of reducing mental ill health in the offender population. We explore potential approaches to this training with a focus on systems and the interpersonal, drawing on joint training used in the MHS and CJS context to

illustrate these approaches and to identify successful strategies which could be pursued over the long-term.

Addressing mental health in through enhanced collaborative practice

Enhancing collaborative practice between professionals, and between agencies, from a wide range of services and disciplines, is high on current political agendas. National inquiries into critical incidents breaching patient safety (e.g., Laming, 2003; Kennedy, 2001) highlight consistently poor collaborative practice between a wide range of professionals including those in the police and health services. A global ageing population (reflected in the prison population - Fazel & Baillargeon, 2011) is associated with greater incidence of longer term conditions that require the input of several professionals and agencies in their resolution. In addition we live in a rapidly changing and complex world of service provision, with high levels of specialisation of services and professionals. Professionals are increasingly required to provide integrated care across professional and disciplinary boundaries. Key policy drivers (IOM Health Professions Education: A Bridge to Quality (2003); Lancet Commission (Frenk et al., 2010), Framework for Action on Interprofessional Education and Collaborative Practice (World Health Organisation-WHO, 2010) and professional consortia such as the UK (National Collaboration for Integrated Care and Support, 2013) reflect this need.

Collaboration and collaborative competencies are also essential for social innovation. Defined as *"the development and implementation of new ideas (products, services and models) to meet social needs* (European Commission,

2013;p6), social innovation occurs through the creation of new social relationships or collaborations across disciplinary or professional boundaries. In this way disciplinary knowledge is shared and new innovative solutions created by a synthesis and coproduction of these diverse knowledge resources (Hean, Craddock, & Hammick, 2012; Hammick, 1998). Social innovation and collaborative practice between MHS and CJS professionals is required if the issues that arise when mentally ill individuals come in contact with the criminal justice system (e.g. in the police station, court or prison) are to be addressed (World Health Organisation, 2005; Bradley, 2009; Durcan et al., 2014). Effective partnership working between these systems means early diagnosis of the offender, treatment, appropriate sentencing or diversion into the MHS. However, collaborative practice at the interface of the MHS and CJS can be challenging, (Hean, Warr, & Staddon, 2009), lacking shared protocols and agreed timeframes, poor information sharing and lack of clarity on lines of responsibility.

There is a range of practice models aimed at reducing mental illness in offenders. These include diversion and liaison schemes (see Rogers and Ormston this volume), specialist mental health courts, care coordination and service level agreements (Bradley, 2009). For success in these innovative service re-organisations, zones of collaborative practice between professionals from the culturally distinct mental health and criminal justice systems, need to be established and to function effectively. Similar innovation is required to fill the grey spaces that lie between services (Department of Health and Welfare, 2013) into which complex offenders fall when no agency takes responsibility for the offender or their mental health needs (see Pycroft and Green this volume).

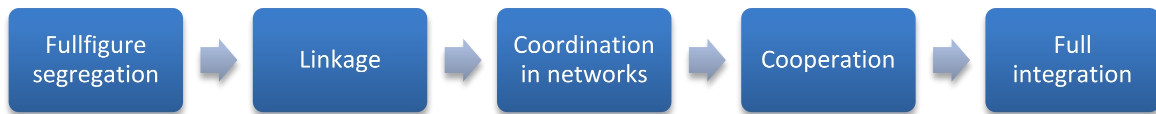
We argue that whatever the service model or innovation used, professionals within the MHS and CJS systems need preparation and training for collaborative practice. In this way current models of interagency working will be sustained and the socially innovative models of interagency working required in the future will be developed.

The case for training for collaborative practice

To improve offender mental health, the UK Bradley report (Bradley, 2009) called for joint training between MHS and CJS organisations. It failed to suggest the content or format this should take as does the subsequent *Report on Bradley five years on* (Durcan et al., 2014). Staff training has subsequently focused on training frontline staff in the CJS on how to recognise mental illness (Ministry of Justice & Department of Health, 2011) with only passing reference to referring clients to the appropriate mental health specialists. Hean et al. (Hean, Heaslip, Warr, & Staddon, 2011) proposed that this joint training should not only be about mental health awareness in the CJS but include training that crosses organisational and professional boundaries and prepares professionals from both systems to collaborate; to learn with, from and about each other to achieve better offender mental health outcomes (see Canton this volume; Rogers and Ormston this volume).

A distinction should be drawn at this juncture between uniprofessional, multiprofessional, interprofessional training and interagency training. Professionals can learn about the role of other professionals in a uniprofessional environment in

which no contact or interaction with other professional groups or professionals takes place. They may also learn multi professionally where multiprofessional education is defined as: “Occasions when two or more professions learn side by side for whatever reason” (Barr et al., 2002; p.6). Multi-professional learning often involves large numbers of students being taught together at the same time, in the same space and about the same topic. Whilst there may be efficiency savings, Carpenter & Hewstone have indicated that ”simply putting students together in mixed classes…(may be)…. unproductive’ and breed poor intergroup attitudes” (Carpenter & Hewstone, 1996; p.241). On the other hand, interprofessional education is defined as occurring “ when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes (WHO, 2010; p. 13). In operational terms, this leads logically to a model of small group learning rather than large group didactic teaching. It is in this latter environment that students develop the internal resources they require to be effective collaborators and/or team members. A focus on the professional mix of the student group takes a micro level of analysis. However, in a patient’s care pathway, interactions between professionals often occurs at a more macro level of work organisation. Multiple agencies can be involved. It is in this context that interagency training approaches are to be considered. Although there will be overlap between the interprofessional and the interagency, the distinction between these two levels of analysis is not entirely clear. Although interagency training will have a component of the interprofessional, interagency training must also take into account greater levels of complexity as students learn to cross both professional and organizational boundaries.



The development and evaluation of interagency training has received less attention than interprofessional training. Where it is developed, in the context of safeguarding children, it is shown to impact positively on collaborative practice (Patsios & Carpenter, 2010). Interprofessional education is more widely reported in the literature but where this occurs it is largely described at the interface of health and social care professional training (Department of Health, 2001). There is no equivalent that includes professionals from the CJS. Despite limited interagency or interprofessional training, MHS and CJS professionals strongly endorse the need for this type of training and its contribution to enhanced collaborative competence across the workforce and, in the long term, improved offender mental health (Hean et al., 2012). Higher educational institutions and educational commissioners from Ministries of Health and Justice are amongst the key players that must address this deficit.

Interdependence between education and practice systems

The Lancet Commission Report (Frenk et al., 2010), when addressing future directions in medical education, emphasises the importance of interdependence between education and health systems: practice, social & policy drivers demand a

workforce able to work collaboratively. Educators need to provide collaborative training that responds to this demand in both quality (the right type of collaborative skill) and quantity (sufficient number of workers with these skills). The same interdependence exists between the criminal justice systems and the systems of education training new legal and security professionals. Health and/or criminal justice systems respond to population needs (in this case offender mental health) by harnessing the range of professionals/agencies required to deliver integrated services that are best placed to address the rapidly changing and complex needs of mentally ill offenders. We suggest that only with close interaction between the education systems and health/criminal justice systems will there be a workforce of sufficient quality and quantity to meet this service demand.

In other words, education systems must supply qualified professionals that are collaborative-practice ready (WHO, 2010) and able to cross professional and disciplinary boundaries in such a way that best serves current and future practice needs. The education systems need to keep abreast of rapidly changing practice needs through continuous dialogue between themselves and health/criminal justice systems. An example is described by Hean et al., (2012) reporting on a series of focus groups that explored the opinions of mental health and criminal justice professionals' attitudes towards interagency training. Focus group participants from both the MHS and CJS called for training that would enable them to understand the other agency from both a systems level and at a more micro level in which positive relationships between individual professionals could be built. Following on from this, a UK higher education institution engaged with professionals from both the MHS and CJS systems to explore the current requirements of

collaborative interagency training that MHS and CJS professionals believed would improve professionals' ability to collaborate and innovate with the common goal of enhancing the mental health of the offender population (Hean et al., 2012) (see Box 1).

Box 1: Example of the outcomes of engagement between the MHS/CJS systems and a Higher Education Institution regarding training needs for professionals related to collaborative practice skills

At a systems level, MHS and CJS professionals say that they would value training that gave them a greater knowledge of the components of other agencies, especially to understand the roles and responsibilities of professionals in other agencies and gain an overall understanding of systems and how they fit together (Hean et al., 2012). They wanted to understand the legal and political environment of other professionals/agencies. This is important as they currently find it difficult getting hold of the right person/service they require in other agencies. This sentiment is not unique to the CJS and MHS. The need for an increasing knowledge of other agencies and interagency training has been at the forefront of many other service interfaces including those linked to the child safeguarding agendas for several decades although the impact of interagency training on practice change and patient/client wellbeing is notoriously difficult to establish (Charles & Horwath, 2009).

At a micro level of interpersonal relationships, MHS and CJS professionals saw interagency training as a means with which to network and build those relationships

necessary to enhance interagency working, improve and share good practice. They wanted to learn to work together to enhance their professional practice and ultimately the wellbeing of the offender with mental issues. They recognized that other agencies have different priorities and values and that understanding their alternative perspectives, targets and priorities will facilitate the building of more effective interagency relationships. They wanted to build empathic relationships with other agencies. Without this interagency empathy, they believed prejudice builds, communication channels and information sharing are blocked and misunderstanding of where lines of accountability lie occurs. These empathic relationships are important at all levels of the professional hierarchy but were seen as particularly important horizontally between senior managers across agency boundaries (Hean et al., 2012)..

We now turn to specific approaches to collaborative practice training within the MHS and CJS context. The first takes a systems approach to training and the second focuses on enhancing collaborative practice professional relationship at a micro level of analysis.

A systems approach to collaborative practice training between MHS and CJS professionals

Social innovations are defined as:

" *complex process*(es) *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**."* (Westley, 2010; pp. 2-3).

Social innovation, viewed at this systems level, requires the variety of actors working together to take an organisational or macro level view to the process of knowledge exchange and coproduction between different professional groups and organisations. At this macro level of analysis, training aimed at enhancing collaborative practice must focus on preparing individuals or teams of individuals to be able to improve the management structures that promote interagency collaboration and through which contemporary policy drivers and guidance on mental health issues may be implemented (see Rogers and Ormston this volume). Collaborative practice between the MHS and CJS at this level is described as a process of inter-organisational integration, one which describes the quality of joint effort put in by two or more organizations and their constituent professionals to collaborate with one another (e.g. between the police forced and a community mental health team).

Levels of inter-organisational integration exist on a continuum from full segregation, with no contact between service providers, to full organizational integration where newly established organizations are created to promote collaborative behaviours. Linking, cooperation and coordination are levels of integration that lie between these two extremes. There is no one model that is generically better than another; optimum level of inter-organisational integration depends on context and service user need (Ahgren & Axelsson, 2005). Service managers from the MHS and CJS

respectively must develop the skills and knowledge to be able to judge the right level of integration between their constituent organisations to achieve the best outcome for offenders' mental health within their own context. These skills can be developed, for example, through application of an assessment tool such as the Scale of Organisational Integration, that quantifies levels of inter-organisational integration, required for optimal interagency collaboration (Ahgren & Axelsson, 2005). This tool has made a unique contribution in other clinical areas (namely child health and rehabilitation) and has potential for both service development and collaborative practice training within the MHS/CJS context.

Another systems level approach that has relevance to collaborative practice training and integrated working across the MHS and CJS at a macro level is that of the Activity System (Engeström, 2001; Hean *et al* ., 2009). The activity system framework is an evolution of socio cultural learning theory (Vygotsky, 1978) . The basic tenet of this theory is that the meaning we make of an activity, or the learning that takes place during this activity (see de Lacy this volume), 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 CJS (e.g. lawyers, judges, and probation officers) (Figure 1) and professionals in the mental health and related services (e.g. psychiatrists, community psychiatric nurses, psychologists) (Figure 2), represent two separate activity systems.

In each single activity system (see Figures 3 and 4), the **subject** is the person within an agency undertaking a particular activity. The **object** is the purpose of this

activity. In the legal system (see Figure 1), the subject is illustrated by a magistrate dealing with a defendant, who has been identified as having potential mental health issues. 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 (see de Lacy this volume).

Surrounding this mediated activity is a range of other variables that may have influence on the actions of the key players. These include the unwritten social norms and formal rules that govern the way in which the legal system functions (see Arrigo and Bersot this volume), 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 fulfill 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 (see Figure 2), when this system interacts with that of the mental health services. There is a mismatch 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 (see de Lacy this volume). 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 CJS. 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 is underpinned by 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.

A community of other professionals surrounds the psychiatrist and their report writing activity. This community includes other psychiatrists, community psychiatric nurses and social workers. A clear cut division of labour between these professionals occurs during 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 circumstances or screening reports are conducted by other health professionals in some areas. The outcomes of this activity can be challenging because of the mismatch in expectations between the content the MHS (the psychiatrist in this case) believes

should be in the report and what, on the other hand, the CJS (the magistrate in this case) requires of the report. The magistrate hopes for guidance on the relationship between the offence and the offender's mental health as well as advice on appropriate sentencing that both protects the interests of public safety as well as the health of the offender. However, the psychiatrist is bounded by norms of patient confidentiality: they may be ill-informed on sentencing options etc., or may argue that offering advice on appropriate sentencing is not within their professional remit. The end result of the interaction between the two systems is that expectations of report content and timeframes are not clearly communicated (Hean, Warr, & Staddon, 2009).

FIGURE 2 HERE

In considering inter agency working, service leaders within the MHS and CJS need to look beyond the two separate activity systems in isolation and review them in parallel, identifying how the objects of each activity may be synchronized, where contradictions in the systems lie (as illustrated above) and how joint solutions can be created in partnership and tested out in practice (see Figure 3). Collaborative practice training can facilitate this process by bringing MHS and CJS professionals to perform this task, enabling them to share their disciplinary knowledge of their own activity system and co-construct new ways of working collaboratively. The innovative solutions they develop are contextually specific to the agencies involved in these crossing boundary activities (Engeström, 2001; Hean et al., 2012).

FIGURE 3 HERE

A micro level approach to collaborative practice training between professionals within the mental health and criminal Justice systems

Building empathic relationships

MHS and CJS joint working can be also be visualized at a micro level. Here collaborative practice training focuses more on the individual behaviour of different professionals and the relationships between them rather than the whole system in which they operate.

Building empathic relationships between MHS and CJS professionals is essential for effective interprofessional collaborative working (Adamson, 2011) and can, in turn, enhance professionals' ability to empathise with the patient/client (Reynolds, Scott and Austin 2000). Such relationships originate from:

- an understanding of roles; appreciating differences;
- exploring the perspective of the other professionals;;
- recognising professionals from other agencies are "people first and co-workers second";
- developing an intentionality around interagency engagements and how these are managed
- creating dialogic (rather than monologic) verbal communication channels;

- the development of collective spirit (e.g. through shared workload, being inclusive, accepting the expression of another's vulnerability) .

Adamson (2011) suggests that an understanding of the roles and responsibilities of another professional, and their scope of practice, is not sufficient to build interprofessional relationships. Professionals must also develop an understanding of the working context of the other agency professional and how they perform the roles they are tasked with. This suggests that a divide between systems level and micro level approaches to collaborative training is not always feasible. Indeed, we would argue that an approach that balances systems level approaches with those that take into account the professional as a person are ideal.

In the current financial climate and with restrictions placed on training and the release of staff to participate in this, there is a temptation to rely on online e-provision or self directed study. Collaborative training may be limited to access to an on line directory of the roles of other agency professionals and training be restricted to uniprofessional or uniagency events. These forms of *arms length* training do not encourage an understanding of the context in which the roles of other agencies are performed and hence are not conducive to building interagency empathy. Actual contact between agencies is essential to build the necessary interagency relationships, interprofessional empathy, and the verbal dialogic communication recommended by Adamson (2011)

Contact between professionals from MHS and CJS agencies can be provided in several ways including interagency placements, visits and shadowing opportunities

(see Rogers and Ormston chapter). Whatever approach taken, it is essential a valid interagency learning experience is provided. Interagency placements, shadowing opportunities or formal visits between agencies all provide this validity through inspection of real life, practice based learning opportunities in future interagency training packages. A need for valid training steeped in practice experience also underpins MHS and CJS professionals' preference for training being delivered by fellow professionals rather than outsiders who may be unaware of the localized and practice issues at hand (Hean et al., 2012).

Although establishing contact between agencies is a recognized tool in building relationships and minimizing intergroup stereotypes and prejudice between the criminal justice system and mental health services, contact alone is insufficient (Dickinson & Carpenter, 2009). Whilst interagency placements, visits and shadowing opportunities provide contact, a range of contact conditions must be present for these positive effects to occur. These conditions include that:

- agencies should be working on common goals;
- there should be institutional buy-in from those in authority;
- intergroup contact should be such that participants are on a level and equal footing
- similarities and differences between professions to be acknowledged

(Dickinson & Carpenter, 2009).

If these contact opportunities are left unmanaged however, and left open to serendipitous interagency learning, then the impact of contact may have quite the

opposite effect, stereotypes being reinforced and interagency relationships harmed. Facilitation is key in these events.

Training focusing on the individual or micro level of analysis, should not only consider the conditions required for training, as above. It should consider also the specific collaborative practice competencies that professionals need to achieve.

Collaborative competencies

The Lancet Commission on Education of Health Professionals (Frenk et al., 2010) recommend the generation of core collaborative competencies drawn from global knowledge but adapted to local contexts. These competencies include

- interprofessional team working
- interprofessional communication,
- role clarification,
- conflict resolution,
- second order reflection and
- collaborative leadership.

Collaborative leadership is stressed as particularly important for 21st century public service professionals who, as service leaders, must operate in multiprofessional, multiagency environments to achieve change within and around their own services. They are responsible for establishing structures to ensure communication, information flow and that collaboration takes place. Part of this competence is

awareness of the impact of management on staff collaboration and service user outcomes.

A range of competency frameworks are available for trainers to draw upon that spell out the domains and detail of collaborative competencies that MHS and CJS professionals should be able to demonstrate (see Table 1).

TABLE 1 HERE

Although the Lancet Commission (Frenk et al., 2010) recommends a move towards competency based training for collaborative practice, training for MHS and CJS professionals that adopts a purely competency based focus may be accused of taking an overly behaviourist focus on the outcomes or required skills and knowledge of training in isolation. A constructivist approach offers insight into *how* training is delivered provides some balance and is exemplified by adult learning methods. We offer here action learning as one example of an adult learning approach, one that focuses on the process of learning in addition to its outcomes:

Action learning

McGill and Brockbank (2004) define action learning as *'a continuous process of learning and reflection that happens with the support of a group or 'set' of colleagues, working on real issues, with the intention of getting things done*' (p.11). This approach has been used successfully in the prison setting to enable particular developments in practice, such as:

- implementing clinical supervision in prison healthcare (Walsh et al., 2007);
- promoting partnership working amongst prison officers and nurses (Walsh, 2009);
- developing a learning environment in the prison health care setting (Walsh & Bee, 2012) and in
- developing a multiprofessional assessment tool to identify the health and social care needs of older prisoners (Walsh et al., 2014).

The use of action learning in the prison setting has two functions. Firstly, specific issues for practice (both security and health care) can be identified and addressed. However, as a result of using action learning as the approach to supporting developments in practice, professionals from a range of services engage in experiential learning, both from and with one another, that brings significant improvements in cross disciplinary understanding and appreciation, leading to more effective interprofessional working.

Using two examples from practice, we demonstrate how action learning that includes both health care and prison staff not only develops practice and impacts on prisoner patient care, but can promote learning and strengthen professional relationships through mutual understanding and respect.

Example One: Developing Clinical Supervision in Prison Health Care Settings

In the first of our examples, action learning was used to develop clinical supervision in prison health care settings, and included both health care staff and prison officers. Specific details of the methodological aspects of this project can be found in Walsh et al., 2007.

Bishop (2007) defines clinical supervision as:

‘a designated interaction between two or more professionals within a safe and supportive environment, that enables a continuum of reflective critical analysis of care, to ensure quality patients services, and the well being of the practitioner’. (p. 1)

In general, clinical supervision has a number of functions including emotional support, opportunity for reflection and constructive critique, enabling the maintenance of practice standards, and the acquisition of new knowledge. Whilst the terminology may reflect a ‘clinical’ perspective, it is suggested that clinical supervision is important and valuable for non-clinicians who have responsibility for the care of others, including prison officers.

The initial phase of this three phase project was centred on the provision and development of a training programme that prepared 35 staff from five prisons in England to facilitate clinical supervision back in their own prisons. The subsequent evaluation of this programme led to its refinement and further adaptation to enable the second phase of the study where 71 nurses and prison officers were trained as clinical supervisors across England and Wales. It is phase three of this study which

is of interest to us here, as it is in this phase where the 71 nurses and prison officers were configured into seven regional action learning groups in England and Wales in order to support them to develop clinical supervision back in their own prisons. 31 prisons were represented across the seven action learning groups, with the composition in five of them consisting solely of nurses. However, there were two action learning groups in which prison officers were members alongside nursing staff. One comprised of two prison officers working as suicide prevention officers, and the second consisted of one mental health nurse and four prison officers working together on a specialist unit for prisoners with dangerous and severe personality disorder (DSPD) (see Scally this volume).

The evaluation of the work and experiences of these action learning groups led to debate about the importance of terminology when engaging professionals from any background to undertake clinical supervision. Therefore, what would be known as clinical supervision was termed practice facilitation by one group who felt this better reflected their aims and purpose. Underpinning effective clinical supervision is the ability to reflect on practice, the ability to think explicitly, review and plan change in one's own professional behavior and its outcomes (Schon, 1983). This was viewed as quite a challenge to some group members, particularly prison officers, who work in what we term a 'closed culture' where prising open practice for exploration is not commonplace (Freshwater et al., 2012). By remaining closed to reflection, prison staff protect themselves from the emotional challenges and potential impact on their own mental health. This reluctance to engage is what Menzies Lyth (1998) refers to as a defence against anxiety, The value of a psychologically safe space for prison staff to reflect on their practice and engage in both clinical supervision and action

learning cannot be underestimated. Through this project, it became clear that the venue for the meetings, which was always away from the prison, was valued by participants as distractions from practice were avoided. In addition to the venue, all action learning groups worked to a contract, which outlined expectations and highlighted particular issues around confidentiality. This assisted in ensuring a safe space for open and honest discussion of issues and enabled effective reflection. In those action learning groups, where officers and healthcare staff worked alongside one another, it was noted that there was an increased appreciation of professional roles and perspectives, leading to new understandings and shared knowledge. Both interprofessional action learning group members reported benefits that included a better understanding of each other's roles but also improved opportunities for networking amongst others in their prisons.

In the second of our examples, we report the experience of a project where action learning was used to promote shared reflection on practice between nurses and prison officers working in prison segregation units.

Example Two: Promoting Shared Reflection on Practice between Nurses and Prison Officers Working in Segregation Units

Following work to develop reflective practice in prison health care settings (see Walsh et al., 2007) the importance of reflection and its significance for interprofessional working led us to consider the value promoting shared reflection between prison officers working in segregation units and mental health nurses working with them in caring for segregated prisoners.

A study was designed to support prison officers and nurses to learn and work together to promote and improve partnership working through reflection on practice (Walsh, 2009). There are significant challenges for prison officers working in segregation units, where violent and difficult to manage prisoners are often located. The high incidence of mental ill health amongst the prison population, has led to a greater awareness of prisoners in segregation units whose violent and aggressive behaviour can be linked to mental health issues. Consequently, there is usually a close relationship between healthcare staff and segregation unit staff, where a joint approach to care can be adopted (see Gatawa this volume). Indeed, some segregation units have been renamed 'care and separation units' as their focus shifts to incorporate a rehabilitative, treatment focused approach. However, some prison staff find the rehabilitative focus challenging where segregated settings have predominantly been modeled on philosophies that are rooted in punishment and control (see Canton this volume; Arrigo and Bersot this volume). Similarly, mental health nurses can struggle with practicing in an extreme secure setting where care and discipline are competing priorities (see Coyle, 2005; see Gatawa this volume).

In order to promote effective interprofessional working between health care and segregation settings, action learning was employed as the means of delivering training that promoted collaboration between MHS and CJS professionals. Two action learning groups, with representation from four prisons in each, met monthly over a six month period. From each prison, one segregation unit officer and one nurse attended. The groups were held away from the prison, where distraction would be minimal. From the evaluation of this work, two key gains were identified

which were prisoner care and staff support. The shared reflection on practice enabled a better understanding of roles and culture, which fed through into changes to the way staff interacted and supported one another. Interestingly, whilst nurses and prison officers are deemed to be from different professional groups, staff in this project identified very little difference in their overall aim for attending the group. The improvement of prisoner wellbeing was noted by both professional groups as their primary and common goal.

Following the completion of this study, the project team received reports that some action learning group members found the experience of action learning and reflection so valuable that they continued to meet back in their prisons to ensure developments and support could continue to progress. It was felt that the action learning groups provided members with the opportunity to take control of their practice and try new ideas with the support of their colleagues. We are certain that prisoner patient care was positively affected by this work as strategies to manage difficult prisoners and situations were discussed in the action learning group, enacted back at the workplace, then reflected on at the next action learning group meeting. Further details of this study can be found in Walsh (2009).

Our reflection on these two examples from practice clearly demonstrate the value of interprofessional action learning and reflection on practice where professionals that come from a different philosophical base, i.e. caring and discipline, can come together to improve prisoner patient care, whilst developing a supportive environment for themselves, in what is a particularly challenging place to practice.

Towards a model of collaborative practice training for the MHS and CJS

A three phase model of training for collaborative practice (Table 2) is proposed based on the above discussion. Participants should be drawn from regional services in the MHS/CJS deemed by service leaders to be at the MHS/CHS interface. A mapping exercise may need to be performed to identify the services and individual professionals that work at this interface, and who should therefore be best placed to benefit from such interagency training.

TABLE 2 HERE

It is essential at the end of this model of training that an evaluation phase is included, with participants reconvened for this activity. The acquisition of the range of collaborative competencies by participants should be assessed and their perception of the interagency networks and relationships they have developed evaluated. In addition, the success of the strategic plans implemented by each team should be explored in terms of the effectiveness of these plans in reducing contradictions between services and achieving optimal levels of integration between them. Last but certainly not least, the impact on offender mental health in the longer term should be assessed.

Conclusion

Collaborative practice is an essential skill required of professionals in both the MHS and CJS if they are to work together in such a way that that the

mental health of offenders who cross MHS /CJS boundaries do not fall into the grey gaps between services that leads to poor mental health outcomes and reoffending. It is also essential to realizing policy and practice developments which have followed from the Bradley Report (see Durcan et al., 2014). Although training in collaborative practice is currently undersupplied, despite the demand for these skills, there is a wide range of approaches to training in collaborative practice available. These warrant further support and development. Training of this type must take into account a systems level approach where the position of the individual professional within the wider organizational and systems can be viewed and viewed as a function of the interaction between the individual and the components of these systems. Training must also look at a micro level of analysis building good interpersonal relationship between professionals within the MHS and CJS. It is important at this level that that the outcomes of collaborative practice training for each professional are clearly articulated and there is opportunity now to transfer and adapt the well developed competency frameworks developed elsewhere to the MHS and CJS training setting. A balance must be achieved however between the outcomes of training and how to achieve this: processes framed by various adult learning approaches including action learning must be kept in mind in achieving these goals. If this is achieved, and training of this form is commissioned by local and national bodies, the MHS and CJS workforce will be better able to work collaboratively in the interest of reducing mental ill health in the offender population. The proposed triple phase model of collaborative training is a step in this direction.

Table 1: Exemplars of collaborative competency frameworks and competencies to be attained by MHS and CJS professionals.

model	Country	Domains	Exemplar competence
Metacognitive Interprofessional competencies model (Wilhelmson et al. 2012)	Sweden	• Teamwork/group processes • Reflection & documentation • Communication • Shared knowledge • Ethics	Shared knowledge: Awareness of general laws/rules for all health/social professions.
Core competencies for collaborative practice framework (IPEC, 2011)	US	• Teams and Teamwork • Roles/Responsibilities • Communication • Values/Ethics	Roles and responsibilities: Communicate one's roles & responsibilities clearly to patients, families, other professionals.
National interprofessional competentcy framework (Orchard and Bainbridge, 2010)	Canada	• team functioning • Communication • Patient-centred care • Role clarification • Conflict resolution • Collaborative leadership	Collaborative leadership: co-creation of a climate for shared leadership and collaborative practice
Interprofessional capabilities framework (Walsh, Gordon, Marshall, Wilson, & Hunt, 2005)	UK	• Interprofessional working • Knowledge in Practice • Reflection • Ethical Practice	Interprofessional working: ability to lead/participate in interprofessional team and wider inter-agency work, to ensure responsive, integrated approach to care/service management focused on the needs of the patient/client

Table 2: A triple phase model of training for enhanced collaborative practice (TCP) at the interface of the MHS and CJS

Phase of training model	Content/Mode of Delivery
INTRA-AGENCY PHASE 1 General awareness training.	This phase may be delivered separately within each agency. For criminal justice staff training on mental health awareness could be included (Ministry of Justice. & Department Health., 2011) These might vary in content but could include awareness about: neurosis; psychosis; personality disorders; learning disability; the difference between primary and secondary care, country specific mental health acts and mental health treatment pathways. This training could be delivered by local mental health services and local criminal justice agencies, or be provided by local training agencies or universities. On the other hand, mental health staff working in local community mental health teams could receive training around how the criminal justice system works – what happens at the police station, courts, probation and prison and basic information on policy driving these services (in the UK for example, the Police And Criminal Evidence (PACE) Act 1984 and sec 136 of the Mental Health Act (1983) (amended 2007) (Hean et al., 2012). All agencies should receive some basic input on contemporary social innovations at the interface of the MHS/CS (e.g. in the UK the Mental Health and Learning Disability Liaison and Diversion agenda including the purpose of the agenda, what the benefits will be and how agencies might work together to achieve them). (Hean et al., 2012).
INTENSIVE PHASE 2 An induction to interprofessional and interagency training	An intensive face-to-face workshop for all MHS/CJS participants (e.g. one or two full days). This serves as a preliminary introduction to collaborative practice. Participants are introduced to definitions of collaborative practice and its importance relative to offender mental health and social innovation within services. Key concepts around

	collaborative practice at both systems and inter relational levels of analysis are introduced. Conditions required for effective contact between professional groups (Carpenter & Hewstone, 1996), the processes behind building empathic relationships across professional and agency boundaries (Adamson, 2011), key collaborative competencies and how these are developed are discussed to promote awareness of relational factors in cross agency working as well as to build empathic relationships and networks between workshop participants. Activity systems models (Engestrom, 2002) are used to articulate interaction between MHS and CJS at a systems level. The workshop should heavily focus on interactive elements, using a cross boundary workshop method (Engestom, 2002) with an offender case study to mirror the work at the MHS/CJS interface. Here participants form interagency teams to explore where contradictions in the overlap between the MHS and CJS systems occur. The Scale of Organisational Integration (SOI) SOI assessment tool (Ahgren & Axelsson,2005) is also employed within these groups to articulate current levels of integration between services and the desired level of integration required to promote offender mental health. Participants then work in their interagency teams to coproduce a strategy and implementation plan to take back into practice to address these contradictions and moves towards an optimum level of integration.
GRADUATED PHASE 3 Implementation of coproduction of interagency strategic and implementation plans and continuous, facilitated learning opportunities to reflect,	Action learning sets are set up between the teams formed in the Intensive phase 2 of the training. Action learning sets are scheduled for short periods (e.g. a couple of hours) across an extended period (e.g. a year). Here participants discuss personal development of collaborative competencies as individuals. They also explore the progress of any strategies designed and implemented as part of the Intensive phase 2 of the training that aimed to resolve contradictions with the overlapping system or achieve optimum integration between

wit support of peers from all agencies, on these plans as well as individual collaborative practices and partnerships.	services. Authentic learning opportunities are also introduced during this phase that may include a portfolio of shadowing, placements, visits, and case conferences.

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