Chapter 13

RESTORATIVE JUSTICE APPLICATIONS IN MENTAL HEALTH SETTINGS

Pathways to Recovery and Restitution

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In this chapter I will introduce two unlikely bedfellows – mental health recovery and restorative justice. It is not an easy union. Conflicts arise when considering them together. Even so, their combination has the potential to bring about creative transformations in the rehabilitation of people with long-term mental health difficulties and a history of offending behaviour. I will start with an outline of the development of restorative justice practices. I will go on to consider the meaning of mental health recovery for those who also have a history of offending and describe restorative justice interventions in such settings. Finally, a preliminary definition of a mode of recovery that accommodates the recognition of harm will be attempted.

THE RESTORATIVE JUSTICE ENCOUNTER

The genealogy of modern restorative justice practice within criminal justice settings has been traced back to the First Nation peoples of Canada, New Zealand, and elsewhere. This refers to practices within so-called tribal societies with which to repair ruptures in the community caused by offending behaviour, without the expulsion of the wrong-doer. It stands to reason that a relatively small grouping of people, trying to

survive in what might be a hostile and isolated territory, cannot afford to simply banish the young men who violate laws or rules. To do so would weaken the collective and quite likely strengthen a neighbouring competitor.

It becomes imperative to find a solution that addresses the needs of three parties. The harmed party must have their harm acknowledged, but instead of punishment, this acknowledgement is focused on restitution. Simply punishing the wrong-doer will not bring back whatever has been lost, but some form of restitution might restore the harmed in some way. There is something else that simply punishing the wrong-doer will not achieve – moral development and motivation to not re-offend. A wrong-doer who is dehumanised in punishment may simply become embittered and resentful, and will perhaps harbour wishes for revenge.

Finally, the rupture in the wider community needs to be repaired. The family of the harmed party need to see that the wrong-doer has acknowledged the damage caused to one of their number, and the family of the wrong-doer need to not be stigmatised and excluded by association. The risk of escalation into factional conflicts needs to be avoided and a cohesive collaborative restored. Braithwaite (1989) has theorised that the process by which these complex, multi-faceted tasks are achieved is 're-integrative shaming'. Rossner (2013) has highlighted the transformative emotional power of the ritual elements of restorative justice processes. An upsurge in interest in restorative justice has seen the emergence of a range of psychological models at the early stages of their development (Gavrielides 2015; Hopkins 2016; Kelly and Thorsborne 2014).

Re-integrative shaming can occur when a wrong-doer comes to a community gathering, typically with elders presiding, in a state of shame. Through a process of detailing the harm caused, more layers of harm than they may have conceived of emerge. Harm to the party they wronged, but also harm to their own family through their shame and the damage to the family's reputation. This significantly increases the wrong-doer's shame and creates the impact that is necessary to bring about the emotion of remorse. What differentiates this from what Braithwaite (1989) refers to as 'stigmatic shame' is that the wrong-doer is given a choice. The slate will be wiped clean if a form of restitution is paid.

Restorative justice interventions may be unique in providing this three-sided benefit in a single action. To be effective, the theory would suggest, this requires the powerful and emotionally violent act

of deepening shame in a wrong-doer. This power is transformative as opposed to destructive, in so far as it is driven by an expression of hope – hope that the harmed can be healed or soothed; that the wrong-doer can be reformed and re-integrated; and finally that the cohesion of the collective can be restored with justice seen, and felt, to be done. This is not without risk. Go too far and the wrong-doer is simply wounded. Go not far enough and the harmed is re-victimised. These are finely balanced and high-stakes encounters. They require the powerful exercise of authority, engaged in an act of creativity, in which community is re-fashioned each time.

This dynamic tension is the crux and essence of this chapter. It is only through engaging with psychic pain that the alchemical process of human transformation can be achieved. To be a catalyst of this transformative process, the people who mediate between people in pain must themselves be able to tolerate the violence of creative states. Bion wrote of transformation in psychoanalysis: 'The change is violent change and the new phase is one in which violent feelings are violently expressed' (1965, p.9).

The re-integrative practices described above have been revived in the social practices of some First Nation peoples, through, for example, youth courts and family group conferences in New Zealand (MacRae and Zehr 2004). Family group conferences in a somewhat altered format have now also become widespread in the UK as a response to family breakdown and social services involvement (NSPCC 2009). In justice circles, victim–offender mediation (VOM) developed in a number of local authorities in the 1990s in the UK (Liebmann 2015). This has developed into what is known as 'script-based' restorative justice conferencing (Restorative Justice Council 2011). There are other models and vehicles for restorative justice processes, many involving some form of 'circles'; however, I will focus here on so-called 'conferencing'.

Restorative justice conferencing is intended to be 'victim-led'. In other words, it can only proceed if the harmed person agrees. In fact, proponents of restorative justice argue that victims often feel excluded from conventional 'retributive justice'. This is partly because they want answers to specific and personal questions, partly because they want to express their feelings and, very importantly, many do not want the punishment meted out through retributive justice. With the agreement of the harmed person and then the agreement, however partial, of the

wrong-doer, there is a carefully facilitated, structured meeting. Not just between the two parties directly involved, but also a 'supporter' for the wrong-doer, a 'supporter' for the harmed and, on occasion, a third party.

As much as there is a structure to the meeting, as implied in 'script-based', what happens within the structure should be free and spontaneous. There is an axiom of skilled facilitation of a conference – which is 'don't steal the conflict'. Feelings can and should run high. A single event can only have transformative power if it is impactful, emotional, and challenging. This is no place for complacency. But this can only happen responsibly if there has been a great deal of preparation. Another axiom of conference facilitation is that 90 per cent of the work happens before the conference itself. This is because the facilitator will have met with the harmed person, assessed their resilience, informed them of the process, and given them space to think about what outcomes they would like to see. This can be done in a single meeting, but in more serious cases, preparation can take months. Similarly, the wrong-doer also has preparatory meetings, to assess their suitability for the intervention, to assess the risk of re-traumatisation of the victim, and to prepare them for the format of the meeting. This process is repeated for all main parties. So it can be a misnomer to refer to 'conferencing' as a single event. It is more likely the culmination of a process.

MENTAL ILLNESS AS A DISQUALIFICATION FROM RESTORATIVE JUSTICE PROCEDURES

Until recently, people with significant mental health difficulties have typically been excluded from access to restorative justice procedures. Sometimes this is because of explicit policy exclusion. Liebmann's (2007) definitive text on what works in restorative justice contains one reference to a case in which someone with a mental illness could not participate due to a lack of capacity. This is a notable exception in the literature where the place of mental illness is largely elided. This may have arisen because restorative justice practitioners have not typically had mental health training and fear acting outside of their competence. Cases in which a wrong-doer has a mental illness are by definition 'complex and sensitive' in the terms of the Restorative Justice Council's handbook for practitioners (2011). However, people who have fallen victim to acts perpetrated by people with mental illnesses are also deprived of restorative

justice outcomes, and victims of offences who have mental illnesses are excluded from benefiting from restorative processes themselves.

THE MULTI-FACETED NATURE OF RECOVERY FOR THE OFFENDER PATIENT

Patricia Deegan (1988) is credited with having initiated a profound shift in how recovery for those suffering from severe and chronic conditions is understood. Deegan, a clinical psychologist with a diagnosis of schizophrenia, described a highly individual and personal journey of coming to terms with the presence of clinical symptoms and yet living a full and meaningful life. This distinction between clinical recovery and living well with impairment has come to be known as personal recovery (Slade 2009). Personal recovery emphasises the importance of a positive sense of self, a meaningful life, hope for the future, and, crucially, personal responsibility. Anthony's (1993) landmark paper describing recovery as a vision for the 1990s provides a definition of recovery:

> a deeply personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing way of life even with limitations caused by the illness/offending. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony 1993, p.15)

This concept of recovery is transformative of mental health services when scaled up. Jacobson's (2004) anthropological account of the implementation of recovery identified that recovery can imply a system reform, a service model, and a social movement. Davidson, Rakfeldt and Strauss (2010) describe recovery as fundamentally a civil rights movement. Policy makers around the world have directed clinicians to recognise the implications of honouring a commitment to personal recovery for each service user at the level of system-wide provision of services.

Davidson *et al.* (2010) quote the US Surgeon General's Report from as far back as 1999 exhorting the service delivery community to recognise that 'the goal of services must not be limited to symptom reduction but should strive for the restoration of a meaningful and productive life' (p.455). They highlight that typical phrases used to describe the recovery movement are 'revolutionary'; 'a new paradigm';

'transformative implications'; and 'truly a new era'. To many clinicians these phrases appear to be hysterical hyperbole. As a 'revolution' or a 'new era' the recovery movement could be seen to be passing by many clinicians. In UK forensic mental health settings the primary drivers for the pragmatic implementation of recovery-oriented care have been commissioner contract targets.

It is curious that clinicians have not been in the vanguard of taking up both the challenge and the opportunity of the recovery movement. Some have argued that this can be accounted for by vested interests in the status quo or a lack of resources. Others view the recovery movement as a form of denial of illness (see Evans 2016); that recovery is simply new jargon to justify the withdrawal of services; or that recovery initiatives should replace the oppressive and stigmatising services already in place.

My own view is that while there is an element of validity in all of the above perspectives there is an additional factor. This is prefigured in Anthony's (1993) vision for the future when he suggests that 'Recovery-oriented health systems must structure their settings so that recovery "*triggers*" are present... The mental health system must help sow and nurture the seeds of recovery through *creative programming*... Helpers must have a better understanding of the recovery concept in order for this recovery-facilitating environment to occur' (p.21). 'Helpers' struggle to understand the recovery concept, not least because many believe that there is nothing new that needs to be understood, but also because the imperative to practise evidence-based medicine inhibits 'creative programming'. Mental health systems have lacked a vision or a language with which to 'structure their settings' in an open-ended way that does not 'prescribe' recovery but which creates a palate that can be 'used', in the Winnicottian sense of the creative use of object, to invent a unique and personal outcome. It can be seen as a waste of public funds to direct resources towards an initiative with no proven evidence base. A 'lean' culture of rationing resources cannot easily tolerate the importance of providing a recovery-enabling environment in which superfluity of opportunity is present.

However, if there is a single change in the delivery of services that is enabled by the recovery movement, it is introduction of peer worker roles. The leavening of the introduction of peer workers could provide a transformative ingredient without the prior evidence base of outcomes to justify such a step.

IS RECOVERY IN FORENSIC SERVICES ANY DIFFERENT?

Drennan and Alred (2012) and Drennan *et al.* (2014) have taken up the challenge of implementing a recovery vision in forensic mental health settings with one key adjustment. They challenged the prevailing wisdom that there was no difference between recovery for the forensic patient and a non-forensic patient (Royal College of Psychiatrists 2004). These authors argue that the reality of the offence constitutes a fundamental difference and that this difference permeates all facets of the recovery journey with an additional layer of complexity. The offence can shape clinical recovery, the social inclusion of recovery, and the meaning of personal recovery. It is often the case that recovering a meaningful life with a positive sense of self and hope for the future is more difficult to achieve in the face of a grievous offence than it is in the face of an enduring illness. In order to identify this difference in additional tasks, Drennan and Alred (2012) coined the term 'offender recovery'. Dorkins and Adshead (2011) and Adshead, Ferrito and Bose (2015) refer to the challenges of 'offender identity'.

The parallel nature of these recovery tasks can be seen in the following quotes – one from Anthony's paper regarding mental health, and one from Ward and Maruna (2007) writing about the Good Lives Model of mainstream offender rehabilitation:

> There is the possibility that efforts to affect the impact of severe mental illness positively can do more than leave the person less impaired, less dysfunctional, less disabled, and less disadvantaged. These interventions can leave a person not only with 'less' but with 'more' – more meaning, more purpose, more success and more satisfaction with one's life. (Anthony 1993, p.16)

> What is required at the clinical level is some attention to helping offenders to build a better life (not just a less harmful one) in ways that are personally meaningful and satisfying and socially acceptable. (Ward and Maruna 2007, p.83)

Building on Anthony's definition of recovery to incorporate the offence-related tasks, one could re-work his definition to accommodate the additional facet of offending behaviour in the following way: a deeply personal process of changing one's (offending) attitudes, values, feelings,

goals, skills, and/or roles. It is a way of living a (safe), satisfying, hopeful, and contributing way of life even with limitations caused by the illness/offending. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness/offending.

The descriptions of personal recovery above emphasise the importance of people taking personal responsibility for their illness. However, there is an important distinction to be drawn here. Taking responsibility for illness cannot generally be taken to mean that the person must take responsibility for developing an illness. They do need to take responsibility for their recovery after the fact, but they cannot generally be held 'to blame' for falling ill. Drennan *et al.* (2014) make the point that it would not make sense to ask of someone suffering from a mental illness 'what motivated you to become ill?', but for the offender patient motivation is a central question to be posed in their recovery. Taking responsibility for recovery for the offender patient has implicit within it that the patient takes responsibility for their offending behaviour. Buckley *et al.* (2014) put it thus: 'The change must be in health certainly, but also in ownership of behaviour' (p.585).

My proposal here is that restorative justice practices are a uniquely powerful vehicle for advancing this aspect of recovery and that this could be deployed as part of 'creative programming' in forensic mental settings. This claim is based on the extent to which the organising principle of restorative justice is the focus on the harm that has resulted from actions. For the offender patient, restorative justice practices promote a focus on the harm that has brought him or her to this place. At the same time, these practices create a place for 'the harmed' to participate. I will expand on this below in order to suggest that, just as peer worker roles present a unique opportunity for recovery processes, creating roles for those who have been harmed could similarly provide a source of 'creative programming' to enable interventions with their three-sided benefits.

RESTORATIVE JUSTICE INTERVENTIONS IN FORENSIC MENTAL HEALTH SETTINGS

Cook, Drennan and Callanan (2015) describe one initiative to formally introduce restorative justice processes into forensic mental health settings in the UK. Since that time a small number of forensic mental

health services have trained staff in restorative justice conferencing skills and have begun to implement this approach. It is encouraging that these services have ranged from high security to services for patients with intellectual or learning difficulties.[1] Cook *et al.*'s (2014) evaluation did not include conferencing between an external, stranger victim and a forensic patient. At that stage the project had progressed to the point of applying restorative justice structures to intra-familial violence or infractions based in the institution, where patient-on-staff or patient-on-patient incidents were addressed through restorative processes. The authors describe processes where patient assaults on staff members were dealt with in this way, and they highlight that it required courage on the part of the staff members, who were obliged, as part of the process, to make themselves more vulnerable, through higher levels of personal disclosure about their experience of harm than they would normally engage in with a patient. However, there were early indications that the wrong-doer's capacity to recognise harm was enhanced by the immediacy of the presence of their victim in the room in active dialogue with them, structured as a restorative justice process.

Another approach to introducing victim awareness in forensic mental health has been through the introduction of the Sycamore Tree Programme (STP) (Wood *et al.* in preparation). The STP is an accredited victim awareness and restorative justice intervention offered by Prison Fellowship in prisons across the UK and in other countries. However, it has never before, to our knowledge, been delivered in a forensic mental health setting. In session three of the six-session programme, victim representatives attend the group and, over the course of the session, they recount their experience of victimisation – how it affected their lives, what they and their families went through, and how, eventually, they began to move past whatever happened, even if it will never really be behind them.

In the second session of the first cohort, when the possibility of repair and restoration was put forward by the Programme Tutor, one group member challenged him by saying words to the effect of 'How can you repair when someone has been killed?' In this group, that was a

1 The Mesdag Clinic and the van der Hoeven Clinic in the Netherlands have published Guidelines for Implementing Restorative Justice in Forensic Mental Health: https://files.enflow.nl/fd9938a8-0039-4987-aee4-d3773cabfd43/c3fe5633-659c-46d0-b624-70920d1cd024/projecten/call-2013-13-richtlijn-definitief.pdf

profoundly serious question. It was highly impactful for the entire group when, one week later, the victim representatives arrived and began to describe the circumstances in which their eldest son was killed by three young men in the street one Friday evening. Everyone participating in the group, the learners and the staff team, were deeply moved by this experience. The reality of the shock, the disbelief, the horror, the anger, the pain, the self-recrimination, the 'if only' questioning, the autopsy, the trial, the encounters with the accused in the court, the encounters with the accused's family members – themselves deeply shamed and grieving too – the sentencing, and the trying-to-get-on-with-your-life: these are layers upon layers of reality that most minds cannot conceive of unless it is recounted with the immediacy of a first-person narrative.

It is difficult to predict how a group of offenders will respond to such a story when they are in the presence of the people who have lived through, and continue to live with, what they are describing. Some fall silent and become introspective, some have spontaneously stood up to embrace the victims, and others appear chastened and unsure of themselves. In our initial cohort of 18 patients, one chose not to attend the third session of the group, when the victim representatives attended. In this sense, that person was, technically, a dropout. The reality was something different. The very idea of meeting victims under these circumstances was more than he could bear. He had been challenged as much as he could tolerate already. The impact of this appeared to destabilise the 'dropout' for a number of weeks, only to recover a significantly improved level of engagement in the weeks and months that followed.

Following STP group sessions, patients spoke about being 'moved' by the encounter with the victim representatives – their story and the way in which they related to the men on the programme. A small number of patients in the initial cohort were 'moved' to the extent that their mental state was somewhat destabilised. They needed additional support and opportunities to work through what they had heard and the way in which this challenged them. The STP Course Tutor used a memorable phrase for the way in which the men are invited to be open to the conflict that this might stir up in them – he would invite the learners to 'lean into the discomfort'.[2] In a corollary to this, programme facilitators of this and other offender interventions also need to find the courage to

2 Finlay Wood, Sycamore Tree Programme Tutor.

supportively challenge the learners on their programmes. However, few group facilitators have the moral authority to challenge complacency in the way a genuine and sincere victim of a serious offence can. Just as peer workers can carry a narrative of belief in the possibility of self-change and taking responsibility for recovery in a very different way from the professional worker, so too can surviving victims carry a narrative of repair and restitution in uniquely affecting ways.

The STP is also not the only programme that brings victims and offenders into direct contact. The Forgiveness Project programme Restore (Adler and Mir 2012) and the Khulisa programme Silence the Violence (Worth *et al.* 2015) do similar things. My contention here is that there is a real possibility that the presence of the 'victim in the room' engages with the 'victim in the mind' of the offender in ways that are more powerful and more visceral than the abstract idea of a victim. We are only at the beginning of being able to theorise the impact of this way of working. Nevertheless, there are encouraging signs that for a sizable number of people with severe mental health difficulties and histories of offending, the introduction of actual victims of crime into treatment programmes induces a state of mind in which transformation becomes possible.

RECOVERY FROM HARM – TOWARDS A DEFINITION

How then does someone who has committed a serious offence while in a state of diminished responsibility 'take responsibility' for their offence? There is no one answer to this question as there are many pathways to committing an offence. No single generalisation will suffice. However, the language of victim awareness and restorative justice can create a notion of 'harm', which in turn opens doors to engaging with reparation in ways that the brute facts of what happened cannot. The perpetrator cannot meaningfully 'take responsibility' for acting on a delusional belief. The wrong-doer can take responsibility by acknowledging the hurt, harm, or impact of the event on the person who suffered as a result of their actions. The statement 'I recognise what happened to you and I am profoundly sorry' is a powerful version of taking responsibility. Recognition is transformative – this rehumanises both parties.

This work has given rise to a form of 'episteme' or 'ground for thought' (Foucault 1970) in which it has become possible to conceive of

a description of the facet of recovery that is in operation for the forensic patient. Based on the above preface, I can propose the following as a definition of the processes involved in recovery for anyone who has caused harm:

> Recovery from Harm – the processes by which a person who has caused harm, directly or indirectly, recognises and accepts the harmful impact of their actions, is willing to take steps to prevent future harm, and is engaged in coming to terms with what this will mean for their own future.

It is my contention that a thorough-going focus on the fact of harm caused, and the ramifications of this through restorative justice processes, has the potential to make a unique and powerful contribution to the transformation of the violent states found in the mind of the forensic patient. Through the range of 'three-sided' interventions that are made possible by this focus, the creative states necessary for personal recovery for all of the people caught up in acts of violence may be given a space in which to emerge.

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