23

TRAUMA AND RESTORATIVE JUSTICE

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> Justice is not some abstract thing. It's a force that sits at the very centre of who [we] are … do we have the capacity to shatter denial … and allow suffering to speak … allow every voice to be lifted?
>
> *Cornel West (2015) NACRJ Conference, USA*

The word "justice" can be highly emotive, especially if you have experienced or been responsible for traumatic harm. Annually, millions of survivors of harm and their relatives enter criminal justice buildings, their architecture symbolically representative of the processes (typically experienced as "cold, imposing and distant") that occur following harm (Toews, 2018). Justice conveys the idea that somewhere there is concern for fairness, possibly for peace, and for the well-being of others. These ethics are so fundamental in many societies that these principles are often embodied in roles undertaken by senior legal adjudicators, leaders, and elders in communities worldwide. Coupled with the notion of "restoration" (the act of returning something to a former owner, or place, or condition), in the context of harm, restorative justice (RJ) sounds important and promising of hope in the wake of tragedy or trauma. Important aspirations indeed – how might they translate into practice within services where harm is the *reason for referral* and often a recurrence within the walls of hospitals that are positioned to promote safe treatment for people who have typically lived under threat and struggled thereafter to live safely alongside others.

In her review of the history of RJ as a field of practice, Liebmann (2007) refers to RJ as "the most ancient and prevalent approach in the world to resolve harm and conflict" (p.37). Since the majority of the people who come into contact with prison and mental health services have experienced a personal history of multiple traumas (Dandurand & Vogt, 2020; Fox, Perez, Cass, Baglivio, & Epps, 2015), the historical focus on *punishment* following harm has left our systems ill-equipped to deal with the legacy of trauma, and therefore with comparatively limited options to date for trauma-informed healing. Retributive (penal) systems have a set of aims (Wenzel, Okimoto, Feather, & Platow, 2007) that may unhelpfully compound the harms that

DOI: 10.4324/9781003120766-29

brought residents to the doors of the units in the first place. It has been argued that our failure to "get at these root causes" remains characteristic of our response to offending actions (Oudshoorn, 2016; p.122). We might ask, why would a young person be expected to be willing to take responsibility for their actions when no one is accountable for the harm done to them (Oudshoorn, 2015)?

Justice (of the kind that you either get or you don't) can easily become politicised by campaigners of all persuasions, with the unwanted consequence that the person(s) who define it are rarely the victim-survivors (Goodmark, 2015). People described as mentally disordered offender patients often find themselves treated as both victims *and* perpetrators (McKenna, Jackson, & Browne, 2019). We all have the potential to be made the "other": the appeased or the aggressor. How might the benefits of RJ as an element of a trauma-informed forensic healthcare system best be represented and maximised?

Following Braithwaite's seminal work (2002), RJ is defined as a process that includes a response to offending. This chapter explores how RJ, and more widely restorative *practices*, can be operationalised within mental health settings with the potential to possibly repair some of the harms of trauma with a view to future accountability for not repeating it. The subject of RJ commands a wide and diverse literature today and there is much that this chapter cannot address. The focus here is on the rationale for emboldening the voice of the harmed and including victim-survivor perspectives within and beyond the offender-patient population. If conflict is handled well, this can resonate with the "felt sense" (embodied) experience in mental health settings of containment and safety, and this has the potential to increase trauma awareness and compassion throughout the system, reaching both harmed and harmer identities.

What Is Restorative Justice?

Restorative Justice is an approach to offending which invites victims, offenders, and relevant others to *engage with influence* over the way the consequences of crime are addressed to meet (some of) the needs of the victim(s) and offenders (van Denderen, Verstegen, de Vogel, & Feringa, 2020). The key to RJ is the reparation of harm (Dandurand & Vogt, 2020). With a greater focus on broken relationships than broken laws, the spectrum of RJ practices seeks to achieve moral and social repair with positive psychological consequences (Latimer, Dowden, & Muise, 2005; Lloyd & Borrill, 2020; Braithwaite, 2003; 2006).

The wide definition of what constitutes restorative practice has led some to argue that the term RJ has become too diffuse (Wood & Suzuki, 2016), covering not only criminal but also transitional justice (that is, truth and reconciliation commissions) informed by RJ principles. For simplicity here, the basic model of RJ via its *three pillars* is set out in Table 23.1.

Fundamentally, RJ involves engaging safely in facilitated dialogue with the hope of arriving at shared understanding and/or agreement (Dandurand & Vogt, 2020). Formats for RJ practice might include preparatory meetings, review with supporters, conferencing (face-to-face meetings that tend to follow a scripted schedule), other forms of mediation (where facilitators go between potential participants until there

Table 23.1 Three pillars of restorative justice (Zehr, 2020): addressing the aftermath of crime, encouraging the repair of harm

Harms and needs: crime causes harm and justice requires active repair
• Who was harmed? What was the harm? How can it be repaired?
Obligations: the parties encounter one another and set out how they will repair together
• Who is responsible and accountable and how can he/she repair the harm?
Engagement of stakeholders in the direction of transformation of the relationship
• Victims and offenders have active roles in the justice process.

is sufficient common ground for a meeting), and in some cases letter writing or review that shifts perspectives but may not bring participants into the same room at the same time. Opportunities to participate in what happens next after an offence and to draft agreements post-harm (e.g., plans that will support future safety, tolerance, or well-being, or that more fundamentally set out a recognition of the impact of the wrongdoing) can generate feelings of connection for participants distanced or, worse, damaged by the harm. These are some of the reliable features of restorative justice from the perspective of the harmed who are in a position to engage (Liebmann, 2007).

There is evidence that these features can also be outcomes when the harm directed against the victim has been very serious (Umbreit, Vos, & Coates, 2006) or sustained (Pico-Alfonso et al., 2006). The severity of the impact of an incident is not necessarily a predictor of the interest in, or potential power of, RJ. A critical factor is likely to be a readiness on the part of the survivor to seek healing or perhaps simply acknowledgement of the harm they suffered. Until recently this was not a "formal" option for victims of the harm perpetrated by those with a diagnosis of mental disorder because access to these resources was not on offer (Drennan, Cook, & Kiernan, 2015; Power, 2017). Some of the reasons for this are explored below.

Restorative practices have a range of different goals in different contexts – from offender rehabilitation in the prison system (Calkin, 2021) and diversion from it (Bonta, Wallace-Capretta, Rooney, & McAnoy, 2002) to reintegration, to making amends in communities, neighbourhoods (Ward, Fox, & Garber, 2014; Willis & Hoyle, 2019), and in domestic contexts (Burkemper & Balsam, 2007). Restorative practices generally involve scaffolding ways in which those involved in a crime (as survivors, witnesses, and/or perpetrators) can make a contribution to how the impact of the offending is handled. There is international variability with regard to public perception of the degree of culpability for crimes committed *when unwell*, and by extension, knowledge of the relationship between mental disorder and risk (Whiting, Ryland, & Fazel, 2020). Views as to what extent the person is considered responsible for causing harm inevitably permeate the offer of restorative practices in mental health settings, but have not entirely constrained it. Paying attention to the context and what has happened to people, as well as their mental state at the time of their offending, can offer a way forward: combining healing with/through accountability.

Although hopeful that present barriers to the success of RJ in prisons can be overcome, Dhami and colleagues have argued that RJ has not found the same "significant utility" inside prison settings as it has outside (Dhami, Mantle, & Fox 2009). Some prison systems have an RJ philosophy (Latimer et al., 2005). Many offer victim-offender mediation, community service work, offending behaviour and victim awareness programmes, whereby RJ operates in conjunction with traditional criminal justice, not as an alternative (Miers, 2001). RJ features at different stages of the process: pre-charge, post-charge and pre-conviction, pre-sentence, post-sentence, and pre-vocation. Is has been found to help prisoners achieve the goals of facing up to crimes and repairing damage in preparation for community return (Van Ness, 2007).

What Is the Value of Victim-Survivor Inclusion in Harm Repair?

Situating the experience of people who have been harmed (*victim-survivors*) as pivotal in this chapter, evidence for the value of RJ *for victims* is shared here. On the basis of their findings from a major review of research on RJ in the UK, in which 36 comparisons were made between RJ and conventional criminal justice, Sherman and Strang (2007) report that RJ significantly reduced crime victims' symptoms of post-traumatic stress disorder (PTSD). It also reduced the desire for revenge, improved their satisfaction with the outcomes, and reduced crime-related costs (such as the cost of repeat offending). These outcomes resonate with earlier work in the United States. Informed by 30 years of evaluation research of restorative justice programmes, McCold (2003) analysed 98 such interventions, noting public support for RJ, for victims of offending, and for the process of reparation as key findings. He reported that participation rates in restorative practices were very high and were typically associated with the recommendation to others of the process, and shared support for the value of mediation.

Detailed examination of attempts through RJ to reduce PTSD following victimisation (or secondary victimisation in the case of family members) has since produced some strong (Angel et al., 2014) and other more modest support for RJ over customary justice procedures (Lloyd & Borrill, 2020). Post-trauma symptoms including arousal and reactivity, re-experiencing of the harm, avoidance of cues related to the scene of the harm, anger, negative beliefs, and self-blame have reportedly been lowered by engagement in restorative meetings, particularly if questions (such as "why me, why then?") are met with satisfactory explanations.

Walters (2015) has demonstrated the positive impact of an apology (not offered in all exchanges) for secondary victims, and others who were processing the possibility of forgiveness. Restorative processes foster empowerment because sensitively addressing harm builds strength in the longer term. The following example encapsulates the possibility that something can come from harm, which means that the suffering/loss of another was "not for nothing".

This mother (Paula, whose son was killed by Lawrence) reflects:

> I stood up at the end of the meeting and held my hand out to Lawrence – he took my hands in his and kept saying over and over again how sorry he

> was. Going home in the car I felt as though every bit of energy had been drained from me. Around three days later I felt that, after four long years, I had received some closure on what had happened that night. I would urge anyone who is in similar circumstances to do what I have done.
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> *Paula – quoted in Liebmann, 2007; p.226*

The Risks of Victim Exclusion in Mental Health Settings

Offender-oriented RJ (which might involve a perpetrator in a potentially positive, albeit one-sided, process), even where the outcome includes accountability, has attracted critique for its failure to really involve victim input or redress in the process (Wood & Suzuki, 2016). There are many useful programmes in prison and health services e.g., Life Minus Violence (Ireland, 2007) and Aggression Replacement Training (Brännström, Kaunitz, Andershed, South, & Smedslund, 2016) that support offenders to learn the skills (self-control, moral development, etc.) in order to reduce the likelihood of offending behaviour. Nonetheless, it might be possible to complete such courses with limited engagement as to the impact of offending on those who are deeply harmed by violence. As people, we tend to be reluctant to talk about interpersonal violence and traumatisation; shame can play a central role in avoidance of further exposure or harm and the apparent safety of silence (Nathanson, 1994). However, paying *too little* attention to victimisation, such that a person who had been victimised would not see the value in participation in a restorative process, risks the loss of this viewpoint in recovery, and the opportunity for those harmed to experience repair. This somewhat inaudible exclusion is one of the barriers to restorative practices becoming embedded in hospital culture, as treatment has a tendency to do *for* or *to* patients, rather than working *with or alongside* them.

Organisational failures, poor communication, inflexible practice, and struggles with power as they are played out in teams (Stevens, Hulme, & Salmon, 2021) will also impact on the embedding of quality restorative practice (Liebmann, 2007). Discrimination that excludes those with mental disorder from a restorative process on the basis of the additional presence of mental health needs, is another (Drennan et al., 2015). There are of course situations in which people simply do not want communication with a person who has harmed them, or whose position with regard to accountability is inevitably fragile but not impossible to resource with a suitable infrastructure.

Mercer (2006) asked victim-survivors why they preferred *not* to meet their offenders, and heard that too much time had passed since the offence, I prefer to forget it, I was too angry, my mother was too angry, I have support, and I have other priorities. In mental health settings, the fear of not being taken seriously, or of repeat attack by the same/other perpetrator(s) in some form, has also been articulated. The latter may be a particular pressure in institutions where patients/inmates are resident for years, and trauma histories circulate. Dominance and control are often maintained via implicit threat in the stories of incidents told by peers and staff, often with reputational impact (Edgar, O'Donnell, & Martin, 2003).

There are many voices in the arena of recovery from harm that have historically been under-acknowledged for a multiplicity of reasons. The Violence Abuse and Mental Health Network (VAMHN) have poignantly asked: "why is it that victims invariably report shame, in a way that their abusers do not?"; and "how might we work with people who have personal experience of violence, abuse and mental health problems to generate research questions that actually illustrate pathways to resilience?". Julich's (2006) research highlights a common desire amongst victim-survivors of child sexual abuse to be able to tell their story in a safe forum, and certainly to ensure that there are consequences for the offender, but not necessarily punishment. There are individuals with very specific needs (such as those who have both experienced sexual abuse and also perpetrated it, and may experience exclusion as a consequence of both). Adaptive responses to shame-based beliefs can be fostered once (if) shame is expressed and acknowledged.

Judith Herman's work on justice from the victim's perspective (2005) articulates not only the impact of violence (in this study, against women), but also the impact of the legal proceedings that so often have to be endured to secure a conviction. Herman argues that whereas victims need social acknowledgement and support, the court requires them to endure credibility challenges. Whilst they need a chance to tell their stories safely, courts tend to dissect and decontextualise their accounts. The process inevitably over-exposes victims to re-livings of their experience, hence Herman's reference to court as the "theatre of shame". It is known that histories of trauma, sometimes of much depth, both individually and generationally, are likely to be disturbed by interactions with the justice system (Branson, Baetz, Horwitz, & Hoagwood, 2017). All injustices are intersectional: there is limited point in fair and legal process if poverty and racism have restricted the distribution of life and liberty (see Crenshaw, 1991).

Justice as "an Ever-Evolving, Nuanced, and Lived Experience"

In Western (liberal, democratic) culture, justice is sometimes used to equate the length of a prison sentence with recognition of the harm caused by the offending. However, viewing justice from a dichotomous position (the harmer is convicted or not; they are sentenced, or not; guilty or not; the harmed is a victim, or not) does not usefully include the full depth of the victim-survivor perspective. Researchers, who have listened to the survivors of domestic and sexual violence (e.g., Daly & Curtis-Fawley, 2006), highlight victim views that are neither restorative nor retributive, but carry a focus beyond the damage in the immediate relationship, towards repair between the victim and their community, in some cases. It is important to remember that the majority of interpersonal offences are committed by a person known to the victim: partners, lovers, siblings, friends, neighbours, teachers, carers, and religious leaders with whom (typically insecure) attachments have been further ruptured by the harm. No one approach, RJ included, could ever adequately address *all* the needs of victims of crime (Richards, 2009); equally the option for repair should be available to all.

Table 23.2 Different types of justice interests of victim-survivors (McGlynn & Westmarland, 2019; Toews, 2006)

- What are the consequences of offending for the perpetrator? Consequences as justice: let this not happen again (the significance of harm is highlighted)
- How is the harm recognised? Recognition as justice: more than being "believed" or taken seriously by others, recognition brings support and the experience of being acknowledged (there is some attempt to remedy the injury to self-respect)
- How is dignity embodied in the victim-survivor experience? Dignity as justice (dignity can be embodied in social standing and connectedness)
- How can victim-survivors "have a say; speak out"? Voice as justice (active participation in the decisions and directions of justice processes, bearing witness to harm)
- Can this harm be prevented from happening again? Individual justice may be less of priority than a desire to address underlying causes of crime, Prevention as justice
- In the aftermath of trauma, can a shattered sense of belonging be met/rebuilt with empathy, support, and dignity? Connectedness as justice
- Relationships, safety, empowerment, information, venting, growing, accountability, and meaning are the "justice needs" of people affected by wrongdoing (Toews, 2006)

Based on an empirical investigation of the main justice interests of victim-survivors of a range of offences, including sexual offences, McGlynn and Westmarland (2019) offer a framework of themes that they observe to be "kaleidoscopic". That is, they define a form of justice that has evolved from the process of constant refraction through new experiences or understandings. The most frequently occurring justice interests of victim-survivors elicited in their study through the techniques of Positive Empowerment Approach (EPA) are set out in Table 23.2. Practice-based evidence from restorative practices in prison settings generated a comparable profile of justice needs (Toews, 2006).

From this commitment to justice from the perspective of survivors we can infer the importance of prevention and connectedness as critical in recovery. If these were features of the response to harm, this could begin to undermine the justice gap that failures of the criminal justice system readily generate (Daly, 2016).

Consequences of Injustice: How Can the Impact of Harm Be Addressed?

In the UK we have come a long way from early applications of RJ in the 1970–1980s through to government strategy and endorsement of RJ in youth legislation (Davey, 2005). Consideration is given here to the evidence available that RJ can play a part in current and future Trauma-Informed Forensic Mental Health services in the UK, a more recent strategic development (Drennan & Cooper, 2018; Public Health England, 2021). In both literatures (RJ with/without diagnoses of mental ill-health), there is an acknowledgement that "meaning-making" can be lost in conventional criminal justice systems where the focus is on internalising wrongdoing.

Do we understand why an offence occurred? (Yes; "because this offender is a bad person"?). What will be healing for those affected, even where outcomes include tragedy? ("Keep the risky person away from others, forever if necessary"?). There are many hidden costs in the justice system if such implications are drawn; retributive attitudes sometimes prevail in society (Pycroft & Christen-Schneider, in press) and can undermine access to RJ. In the Netherlands, Zebel and colleagues (2017) studied the seriousness (in terms of perceived wrongfulness, harmfulness, and duration of incarceration) of crimes perpetrated and whether this predicted the engagement in mediated contact between offenders and victims. They found that willingness to participate in victim-offender mediation after very harmful offences did increase over time, whereas it decreased with time where harm had been less impactful.

Sometimes victim-survivors and/or their families urgently require the punishment or safe disposal of an offender. In the UK, the Office of the Victims' Commissioner (2018) highlights the specific needs of families who have been subjected to terrifying offences by those whose judgement is impaired by mental illness, and who may endure the felt and real sense of a lack of ongoing safeguarding and equitable support for their situation. Frequently, victims also seek to understand *why* the offence occurred; why *to them*, and they do have hope that the perpetrator can take some steps towards making amends for all concerned (Donovan & Donovan, 2018).

Harm repair has therefore to be offered as a genuine process for the benefit of victims who suffer with the impact of the harm, with the potential (but no guarantee) for healing (Drennan, 2018). One of the complexities encountered in considering the role of RJ as part of a system of trauma-informed care and practices for mental health is that the majority of offender patients have inhabited both identities: harmed and harmer. Trauma, abuse, and mental health are inter-related (Jonas et al., 2011).

It is known that people with mental disorder are more likely than others to have experienced abuse and to be victimised (Heads, Taylor, & Leese, 1997; Kahlifeh et al., 2015). Those who had experienced psychological abuse suffer the same rates and severity of symptoms (including PTSD) as those who have experienced physical abuse, with a clear implication relating to mental harm and its impact over the lifespan (Pico-Alfonso et al., 2006), in some cases in relation to the harm they have themselves perpetrated (Harry & Resnick, 1986). Additionally, staff in forensic mental health services may be drawn to the work because of the lived experience of trauma in their lives, or then in relation to the impact of facing violence on a regular basis (Jacob & Holmes, 2011; Jacobowitz, 2013).

Not all restorative practices will decrease anger or distress; indeed, a small number of studies have shown the opposite (e.g., Wenmers & Cyr, 2005). As is known from the ever-increasing body of knowledge on trauma, even with the best of intentions, the trauma of harm can be magnified rather than resolved without due care, attention, thought, and preparation. A trauma-informed approach can at least acknowledge the prevalence of trauma on all sides and the importance of creating a sense of safety for those re-exposed through insensitive practices that parallel aspects of offending and re-play loss of control in the person's life (Moore, 2019).

An example from secure hospital practice: when an experienced member of staff was approached about RJ, he exploded with anger expressed at the failures of the system to support him in an impossible role. He had been punched in the face by an articulate patient who had a local frustration (a phone-call with a family member that he found unproductive and reminded him of exclusion and despair). There was no other external provocation for the assault. In turn, this reminded the member of staff of a number of other situations he had faced over a long career in mental health. To make matters worse, he had gone out of his way to assist this patient on that day. His family had been waiting for him to return home from the shift, and this was delayed even further by his having to go to the Accident and Emergency unit for treatment. The break to his nose remains as a visible reminder to this day. About 12 months later, after the patient had sought the opportunity to apologise and to meet, to give an account of his actions, the member of staff stated that he would not want to hear any words of regret about what happened; he would not find them credible. His preference was not to "play the game of RJ". Another six months on, he decided to engineer his own response. The patient and staff member eventually shared their contentment with a resolution fuelled at first by the mutual respect of temporary withdrawal of cooperation on both sides, and thereafter acknowledgement of the potential to harm and the value of genuine, rather than hurried and "false", connection. The member of staff preserved his belief in the importance of his job, a vocation he had committed his life to. The patient learnt that displacement of his anger was not likely to elicit support from those he actually respected, and this shifted his future accountability in a healthier direction. Is there a lack of RJ impact here? Certainly, the process took time and there was no facilitated restorative meeting. Rather, this might be considered a genuinely victim-led process, because the harmed person took control of the timing of his re-setting of the professional alliance – an example of justice with a dignity (Table 23.3) that was very important to both men.

The Application of RJ in Mental Health Settings: Individual and Group Possibilities

The role of the forensic psychiatric hospital is primarily to treat (that is, reduce the risk posed by) those who have committed an offence. Where this is a serious offence (e.g., homicide, assault, other violence), in the context of diagnosable of mental disorder, referral is likely to be a high secure hospital (NHS England, 2019). By virtue of their mental state presentations, cases involving mental illness would be designated as "complex and sensitive" in relation to RJ (van Denderen et al., 2020). Typically, the context in which offenders with mental disorder might reside can present both opportunities (access to RJ) and challenges (e.g., in light of risk, can a meeting progress safely?).

Developments in the South of England within medium secure services have illustrated the range of possibilities for introducing restorative practices, and more fully acknowledge the experience of victims within mental health services (Drennan, in press). In one of the UK's high secure hospitals, the journey towards more restorative

Table 23.3 Principles of RJ practices (after Braithwaite, 2003)

Restoration	Address and repair harm (focus on the future not the past)
Voluntary	Participate at own free will (minimising coercion), accessible
Neutral	Experience fairness and lack of bias
Safe	Non-blaming, non-labelling (very important in Mental Health services)
Trauma-informed	Not compounding of social injury (one on top of another)
Respectful	Maintaining of dignity for all parties
Additional adaptations in mental health settings/for "sensitive" case material: (see Cook et al., 2015; Wild, 2016; Drennan, 2018; Van Denderen et al., 2020; Power, 2017)	
Training	Required to appreciate complexity (i.e., understand trauma) and create the "safe and trusted" context for a restorative process
Preparation	To be more extensive and include review of the seriousness of the offending, the passage of time, mental state stability and risk assessment
Assessed resilience	Of harmers to cope with the experience of re-integrative shaming (ability to hear and accept the impact of harm)
Support	To be offered by the wider system for the process of repair
Co-facilitation	Of RJ meetings, including conferences between RJ facilitators and unit staff
Follow-up	To promote adherence to/review of plans to make adjustments/ allowance for mental state variations

practice started with review of the conflict situations that had led to patients being separated within and across the 210-bed site, and an offer to clinical teams to support restorative mediation to address this. Six years on, the teams can refer patients *and* staff (so frequently the victims of assault, Newman, Roche, & Elliott, 2021) for restorative justice. Some principles underpinning RJ practices and adaptations for complex cases, including cases where mental health/ill-health features, are illustrated in Table 23.3.

By way of example, a member of staff who had been assaulted twice by the same male patient (with an extensive trauma history including of being raised in a country with ongoing civil war, and suffered displacement, discrimination, and abuse) presented his feedback to the RJ team. The harmer (patient X) struggles with persistent paranoid ideas about younger male staff. Sadly, this mental state is enduring. Nevertheless, in spite of this, and after careful preparation, they participated in a restorative meeting, and this quote illustrates some of the gains of the process for the member of staff, the person harmed in this case:

> I wanted to say thank you all for helping me to recover from the incident six months ago. The meeting and support since has helped me to come to a point where me and X [patient] will be working together again; I hope to be able to realise my duty as a professional in helping him to move forwards.

> The whole process has helped me to become a better member of staff and I hope to stay here rather than leaving, as I had considered doing at the start of the year.

The impacts on staff of constant exposure to the threat (Jacob & Holmes, 2011), risk, and reality of violence as a secondary traumatisation are more thoroughly addressed in Chapters 20 and 21 of this book.

The need is acknowledged for staff undertaking RJ in mental health settings to be supported by managers and multi-disciplinary teams, and to allow time for the organisation, training, and procedural plans to be operationalised. This way those most familiar with the patient's hopes and intentions can be involved and advocate where required. In the prison system, the benefit of strong resident/officer relationships is critical to the maintenance of stable prisons and building trust, a critical component in rehabilitation (Liebling, Arnold & Straub, 2015). Similarly, for restorative practices to take hold in any institutional setting, the constructive engagement of the wider context providing a network of support has seemed instrumental for RJ casework (Cook, Drennan, & Callanan, 2015; Moore & Dudley, 2016; Cook, 2019; Tapp, Moore, Stephenson, & Cull, 2020). The same is true for the development of restorative wards (Cooper & Whittingham, in press), where conflict resolution becomes part of community life for residents.

There are limitations here with a literature base in early development: more rigorous formal evaluation is required. It is possible that positive feedback about RJ may be the result of a reporting bias in these studies because "cases" are not randomly selected to participate in the process, but referred on the basis of the presence of need. At this time only qualitative data on referrals that do not take hold because one or other party dismisses them out of hand from the outset is available. However, we can draw on trauma-informed principles to make sense of the (sometimes necessary and protective) shield of avoidance and its origins in intolerable experiences (Tomkins, 1987). This perspective supports a compassionate working understanding of (otherwise) complex and often counter-intuitive responses.

The Application of RJ to Index Offence Referrals

Index offences are those that precede an admission to a mental health hospital or unit. Offending that occurs in the context of mental disorder can be very confusing and distressing for victims, their relatives, and the perpetrators and their relatives (Cook et al., 2015). To address the possible needs of the harmer and harmed in this situation requires a team-based approach and the structure of the RJ process to support and sponsor safety through potentially highly evocative encounters. In their research with offender patients in the Netherlands, van Denderen and colleagues (2020) found that mental stability (in the presence of a diagnosis of psychotic disorder) and realistic expectations about what victim-offender-contact would be likely to involve were associated with better outcomes for RJ conferences in which the harmed and harmers actually met face to face. The research team speculated that insight into the harm generated by offending (and forgiveness by victims) did not necessarily impact

recidivism or treatment goals, but was associated with higher engagement (including in RJ) and demonstrable therapeutic change.

Category of mental disorder was not predictive of engagement in the process, but it was acknowledged that capacity for communication was helpful, as was the management of the victim-offender liaison. This is important, as Willis and Hoyle (2019) found that socioeconomically disadvantaged offenders appeared more likely to experience communication difficulties, and were less likely to be perceived by third parties as sincere or willing to desist from offending. In their research, social disadvantage and street cultural capital emerged as impactful in relation to participation in RJ processes (Willis & Hoyle, 2019).

Working on the index offence, if all (or possibly some) parties are willing, presents inter-agency challenges that can be addressed by partnership alliances. RJ interventions of this kind require that all those involved (staff, patients, participants, other stakeholders) are familiar with how the RJ process will interact with concurrent/future criminal justice processes. RJ is not an alternative to prosecution/conviction, but it can be an opportunity to potentially reduce the impact of high distress and the longstanding pain of unresolved harm and trauma.

From the perspective of both the perpetrator of harm and the harmed person/people, restorative work may assist in emboldening the narrative about the harm and its impact in a way that can address unanswered questions, rumination, and/or other preoccupations associated with it. Even if there cannot be a meeting (in some instances due to death), justice work can support the process of "closure" in situations where narratives are incomplete, unprocessed, and recur/re-appear in the form of nightmares, flashbacks, avoidance, and/or self-harm. Unmet "justice needs" (Daly, 2014) generate unfinished stories, and yet "meaning making" is a critical part of the journey in the direction of recovery from trauma and making meaning of life after loss (Ferrito, Needs, & Adshead, 2016).

The Application of RJ in Mental Health Settings: System-Wide Implications

Shifting the culture of the organisation towards fairness in responding to the risk of harm is a wider aim that is informed by the drive to prioritise safety in healthcare systems. Clear indications as to what are acceptable (safe) and unacceptable (risky) behaviours can be articulated for residents/patients and staff. So-called "just cultures" are fostered by mechanisms promoting awareness, not just an emphasis on liability, wherein contributors ideally learn and develop in an atmosphere of trust (Stretton, 2020). The focus on improvement is assumed to be helpful in raising performance rather than establishing causality (and blame). These principles have resonance in the wider literature on restoration. Just cultures highlight the humanity that trauma-informed practice draws attention to. Practitioners faced with daily encounters that will inevitably impact on their decision-making under pressure in the workplace, or foster omissions in care, are sometimes placed under unique occupational pressures. Repeatedly facing the threat of violence is a good example of such a challenge.

Restorative Foundations for Trauma-Informed Health Systems

Research repeatedly demonstrates the known association between trauma, a major risk factor for illness, and the development of mental ill-health and offending behaviour. Historically the criminal justice system has ignored the problem of unhealed trauma (Pycroft & Christen-Schneider, in press). Preliminary findings about the application of RJ principles in situation of harm of many kinds are promising. Where mental health services work restoratively they find that their relationships are stronger, there is a significant reduction in violence on wards, victims are engaged in the service more meaningfully, and elements of the service are able to engage with conflict and repair broken relationships in a hopeful way (Cook et al., 2015; Cooper & Whittingham, in press). The fostering of empathy between people with a history of harm enables everyone's gifts to contribute to the co-production of responses to harm.

Restorative practices create spaces for listening, for trust-building, reparation, and apology – places in which harming and harmed parties find a new strength to co-exist. Violence is (sometimes) what we do with suffering when we do not know what else to do (Russell, 2020). RJ offers the opportunity to reintegrate *both/all sides* (staff and patients, patients and patient peers, staff and staff peers, the organisation and its stakeholders) into communities that might be able to consider (historical and transgenerational) root causes, and the possibility of a valued life thereafter, in spite of the path of destruction that trauma has engraved. Along with other principles of empowerment, RJ invites us to ask of the harmed and harmer, not "what's wrong?", but "what's strong?", and to support institutions to avoid sustaining the very problems they believe they are solving (Russell, 2020).

Further Reading

Wallis, J. (2014). *Understanding restorative justice: How empathy can close the gap created by crime.* Policy Press. For readers interested in the relationship between empathy, responsibility, shame, forgiveness, and closure. This text explores the journey from harm to healing with compassion and provides a summary for those new to restorative practices.

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