ARTICLE

Restorative justice practice in forensic mental health settings: bridging the gap

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Abstract

The 'clinic' has developed sophisticated systems for responding to the challenge of serious mental health conditions. Mental health services combine hierarchical decision-making processes, with clear medical authority, with interventions that are required to be evidence-based to the highest standard. This is a system in which ethical, defensible practice is imperative to protect the public and to protect practitioners from legal liability in the event of adverse outcomes. Restorative justice interventions are powerful 'medicine'. At their best, they change lives. However, the evidence base for formal restorative justice interventions when 'administered' to people with severe mental health difficulties is almost non-existent. It is into this relative vacuum of empirical support that initial steps are being taken to formalise access to restorative justice for mental health populations. This article will consider the challenges for applications of restorative justice in mental health settings and how the gap between the principle of equality of access and actual practice could be conceptualised and bridged. Recommendations include a rigorous commitment to meeting the needs of victims; a focus on the mental health patient's capacity to consent rather than the capacity to benefit; practice-based evidence development and the inclusion of restorative justice awareness in all mental health practitioner training.

Keywords: restorative justice in mental health, evidence-based practice, institutional settings, victims, ethics.

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1 Introduction

Restorative justice, as a broad set of principles in which the rights and needs of people who have been harmed and the obligations of those who accept responsibility for that harm are considered in dialogue between the stakeholders, has found an enormous array of applications. The social movement of restorative justice has been operationalised in settings that range from nation-building in 'transitional justice', to communities in which crime and disorder disrupt the fabric of social cohesion for individuals and groups, to schools and prisons (Gavrielides, 2021; Johnstone & Van Ness, 2011; Sullivan & Tifft, 2007). One area in which there has been relatively little articulation of the 'how' of restorative justice is health settings, and more particularly forensic mental health settings. By forensic mental health, we mean the services that meet the treatment and rehabilitation needs of people with offending behaviour and mental health needs.

The recently updated *United Nations Handbook of Restorative Justice* (2020) states that 'The restorative justice process can take place in parallel to other forms of intervention (e.g. drug treatment, mental health treatment and supervision)' (p. 8). This simple endorsement of restorative justice practice alongside mental health treatment is an important marker of progress towards inclusiveness and will be a source of encouragement to practitioners and policy makers in mental health settings. The specific impact of mental health issues on the practice of restorative justice does not receive detailed attention in the rest of the handbook, save for a reference to the need for practitioners to consider the victim's mental and emotional states. Interestingly, the guidance for practitioners regarding the offender is to consider their cognitive abilities and their ability to participate in the process. The offender's cognitive abilities and ability to participate are of course crucial to the success of the process. However, the implicit and most certainly unintended implication is to suggest that the offender's cognitive capacity to participate is fundamental whereas the victim's emotional capacity to participate is fundamental. This points towards an important difference for formal mental health services when considering participation in restorative justice – the offender's cognitive, mental, and emotional states are of equal importance.

The European Forum for Restorative Justice's recently published Position Paper in response to a consultation on the Victims' Rights Directive (VRD – Directive 2012/29/EU) highlights the obstacles to access to restorative justice that continue across EU member states (EFRJ, 2021). A lack of awareness of restorative justice amongst referring bodies and organisations that come into contact with victims; the lack of cooperation between the relevant services and the poor quality of information made available to victims are some of the impediments that still cast a shadow over access. In this article, we will consider the ways in which these and other obstacles to access operate in the particular domain of mental healthcare, and more specifically, in the domain of forensic mental healthcare.

The Council of Europe statement concerning restorative justice in criminal matters encourages inclusive practice (Council of Europe, 2018; see especially Rule 27) and the development of enablers to participate, such as the use of guardians and additional information. While the jurisdictions within which restorative justice

or victim-offender mediation is practiced may not have explicitly excluded people with severe mental health difficulties, a lack of guidance and training for restorative justice practitioners and a lack of engagement from the community of mental health practitioners may have had the effect of creating barriers to access. Even with no specific prohibition on the participation of mental health service users, either as victims or offenders, the notion that people with serious mental health conditions could not participate appears to have been a widespread assumption within the restorative justice and criminal justice communities.

There are encouraging signs that the tide may be turning on the commitment to mental health inclusive practice in some areas. Dutch mental health services developed guidance on how victim-offender contact can take place when the offender is detained or cared for by the forensic mental health services (van Denderen, Bax & Sweers, 2016). The Victim's Charter in Ireland has a specific section given over to describing what victims can expect if the person who committed the offence against them receives mental health disposal from the Courts (Government of Ireland, 2020). This includes specific reference to access to restorative justice and the means to register as an involved victim. The recently published Victim's Code (Ministry of Justice, 2020) for England and Wales extended the rights of victims to address their needs if the offender is detained under the Mental Health Act. Victims with mental health and other disabilities have an entitlement, as vulnerable victims, to the support of a registered intermediary. However, there is no explicit reference to how access to a restorative justice intervention can be enabled if the offender has disabilities associated with mental health.

The position we set out in this article is one of seeking to address the gap between emerging aspirations of inclusive practice and the means by which to deliver such aspirations in the domain of forensic mental health. We begin this by setting out the ethical issues for forensic mental health practitioners when restorative justice interventions are considered for their patients. We go on to consider the place of restorative justice, not just as a normative framework for the rehabilitation of offenders, but as a set of interventions that offer the opportunity to meet the needs of victims, and secondarily to, possibly, contribute to the rehabilitation of offenders. We seek to reflect on the experience of the work being done to bridge the gap between the aspiration to make restorative justice available to all and actual practice. We approach this by articulating the nature of the challenges faced by practitioners and a range of strategies through which it might be possible to conceptualise developments in access to restorative justice for both victims and offenders, when significant mental health challenges on either side may foster discouragement or disengagement.

2 Mental health context

Mental health challenges are ubiquitous in every society. There can be no one who has not experienced some form of mental health challenge or who does not know someone close to them who has. An anti-stigma campaign in the United Kingdom

highlighted that one in four people will experience mental health difficulties. As important as it is to highlight the universality of mental health conditions, over-emphasising what is common can obscure significant differences between conditions. What are referred to as 'severe and enduring' or 'chronic and persisting' mental health conditions can be more difficult for the non-mental health professional to conceptualise. The severe mental health conditions typically require hospitalisation from time to time, as well as psychotropic medication, as they are long-term, relapsing and remitting conditions, such as schizophrenia, bipolar affective disorder and other psychotic conditions. The causes of these conditions are seen as a combination of genetic vulnerability, developmental trauma such as adverse childhood experiences (ACEs), socio-economic deprivation and social exclusion. Psychotic conditions can also result from long-term misuse of psychoactive substances and alcohol or from traumatic brain injuries or medical conditions. These are the most serious where there are features of what is referred to as a breakdown in so-called reality-testing. This includes symptoms such as delusions (false beliefs not shared by a cultural or religious community), hallucinations (perceptual disturbances such as hearing voices, seeing things that other people cannot see and a range of other bodily experiences in all of the senses), impairments in reasoning and thinking ability (cognitive abilities), emotional incongruence, emotional instability, and impaired insight and social judgement. Increasingly, neurodevelopmental conditions, such as autism and attention deficit and hyperactivity disorder (ADHD), are also being recognised as separate conditions and which can co-occur with mental health conditions. Learning disabilities or intellectual disabilities are not mental illnesses, but their presence increases the risk of experiencing a mental illness. Personality disorders are not technically mental illnesses, but they are categorised in mental disorder diagnostic manuals. Personality disorder is defined as a persistent pattern of experience and behaviour that begins by late adolescence and which causes distress or significant problems in occupational and social functioning. Personality disorders affect ways of thinking about oneself and others; ways of responding emotionally; ways of relating to other people and ways of controlling one's behaviour. These difficulties can result in periods of compulsory treatment in hospital and are over-represented in prison and offender populations. Some estimates place the prevalence of personality disorder, principally Anti-social Personality Disorder, at between 60 and 70 per cent (Singleton, Meltzer, Gatward, Coid & Deasy, 1998; Tyler, Miles, Karadag & Rogers, 2019).

Restorative justice practitioners will be well familiar with undertaking risk assessments of cases referred from criminal justice agencies in which there is a concern that the harmer will seek to use the opportunity for contact with a victim to inflict further harm. The term 'psychopath' is one commonly used in the media and is generally understood as someone who lacks empathy and seems to take pleasure from controlling others and inflicting harm either through indifference or for the purposes of revenge. Psychopathy (Cleckley, 1941; Viding, 2019) is not a formal diagnostic category in the current diagnostic manuals used internationally but is an operational category used mainly in offender and forensic mental health populations and for which there are assessment measures (Hare 2003; Lilienfeld &

Andrews, 1996). The features of psychopathy are understood to be a severe form of anti-social and narcissistic personality disorders. Not all people with psychopathic features commit criminal offences, and there is some literature describing behaviours in everyday walks of life that appear to be psychopathic (Babiak, Neumann & Hare, 2010).

Restorative justice practitioners might be assumed to be less familiar with casework involving severe mental conditions or neurodevelopmental conditions, the features of which affect the capacity to engage in restorative justice processes. However, restorative justice providers tend not to capture or report on the extent to which their referral base includes people who have mental health conditions and their outcomes. Commissioner-driven contracts for providers focus on caseloads, throughput and offence types, while little attention is given to reporting the demographics of participants. Hansen & Umbreit (2018) have noted the relative paucity of research on the uptake and outcomes of restorative justice for ethnic minorities, and a similar 'invisibility' can be considered for people with mental health conditions. One small but very helpful study interviewed three restorative justice practitioners in the United Kingdom about their encounters with mental health conditions that were not uncommon in their caseloads (Dwornik, 2014). One practitioner described how they were able to progress casework with support from psychiatrists. However, most practitioners were daunted by serious mental illness in clients, and the term 'spider syndrome', or fear of the unknown, provided Dwornik with the title of her monograph. The lack of consideration of mental health issues in restorative justice practitioner training was also noted in this study. In contrast, specific accreditation for working with family violence or sexual harm does take place in some jurisdictions.

3 The theoretical case for restorative justice in mental health settings

The theoretical and conceptual case for the potential value of restorative practice for a mental health population has been made from time to time over the past two decades (Garner & Hafemeister, 2003; Hafemeister, Garner & Bath, 2012; Thomas, Bilger, Wilson & Draine, 2019). The Canadian Mental Health Commission (2012, in Dwornik, 2014) had outlined diversion through restorative justice as a possible method of diminishing the over-representation of individuals with mental illness in the criminal justice system. Quinn & Simpson (2013), also writing in Canada, have argued that if the 'victim's voice' is increased through Victim Codes of Practice, and this is not to be simply a vehicle for retribution, restorative interventions to address the harm and the conflict need to be considered alongside such developments in criminal justice practice. However, there are few existing articulations in the international literature of the issues for the introduction of formal restorative justice practices into formal mental health settings. This is in spite of the evidence that the majority of offences committed by mental health service users are in relation to people who are family members, carers or acquaintances, and hence in a form of relationship to each other (Jeandarme, Vandenbosch, Groenhuijsen, Oei & Bogaerts, 2019). This article will seek to develop

the position set out in Drennan, Cook and Kiernan (2015) regarding the clinical utility of restorative practice, by setting out with the challenges at a systemic or organisational level in a way that has not been addressed elsewhere. The analysis presented here is derived from practice-based evidence developing in projects to introduce restorative justice practice in formal mental health settings, largely in the South of England, and the small body of research evidence emerging through mental health–based projects.

4 Emerging practice-based evidence in forensic mental health

In the first study to examine process and outcomes for forensic mental health inpatients engaging in restorative justice interventions, Cook, Drennan and Callanan (2015) conducted semi-structured interviews with patients, victims, and restorative justice facilitators about their experiences of restorative interventions within a secure mental health unit in the United Kingdom. Overall, the restorative interventions were endorsed by participants as helpful and recommended its ongoing introduction into mental health settings. However, the authors note particular aspects of this context that required special attention when attempting this work in such settings. One such aspect is the need for psychological containment, particularly supporting harmed members of mental health staff to engage in restorative interventions with the patients whom they worked with, as the process required them to tolerate more emotional vulnerability than would usually be the case following an incident in which the staff member was harmed. In a recent study in the Netherlands, van Denderen, Verstegen, de Vogel and Feringa (2020) interviewed 35 social workers about their experiences of victim contact with mentally disordered offenders in 57 cases from four Dutch forensic psychiatric hospitals. They found that there were no mental health conditions or offence types that were automatically excluded from victim-offender contact. However, the timing of the contact, the mental health stability of the patient offenders, the capacity for the patient offender to demonstrate insight, and the ability to comply with agreements on the part of the patient offender were all important factors when there were positive outcomes. It is important to note that the victim-offender contact was not described as restorative justice. However, it is clear that restorative elements were included in the contacts, such as opportunities to ask questions of the offender and the offender making an apology.

There are a small number of published clinical case studies that describe the use of restorative justice interventions in forensic mental health settings. Cook (2019) describes a three-case series with women in secure care, describing a range of outcomes. This is an important contribution to the existing literature, as the paper describes multiple outcomes that may be possible, not all of which conclude with conferencing, but which are nevertheless beneficial to the participants. The paper also discusses the protracted nature of the intervention as a result of the offender patient's fluctuations in mental state. This is an important consideration when engaging the support of restorative justice provider services and managing the expectations of victims, who may experience long delays in progress towards

resolution. Tapp, Moore, Stephenson and Cull (2020) provide a detailed and unique case discussion of the provision of a formal restorative justice intervention with a man with autism and mental health difficulties in a high secure hospital in the United Kingdom, in collaboration with a third sector restorative justice provider. Drennan (2018) described the use of the Sycamore Tree Programme, a victim awareness and restorative justice–accredited programme, in forensic mental health services, and Harvey and Drennan (2021) explore the experience of staff delivering the Sycamore Tree Programme for the first time in a secure mental health facility. The intervention highlighted in these papers demonstrates that it is possible to integrate victim awareness and restorative justice awareness programmes into forensic mental health rehabilitation as a preparatory step towards engagement in direct victim-offender mediation.

There is also a growing 'grey' literature documenting the developments of restorative justice interventions in forensic mental health practice in the United Kingdom and Australia (Drennan, 2014; Drennan & Cooper, 2018; Moore, 2016, Moore & Kiernan, 2017; Moore & Simon, 2019; Power, 2017). Increasingly, mental health practitioners are being invited to contribute conference papers regarding restorative justice initiatives at restorative justice conferences and at mental health conferences (Cooper, Drennan, Tapp, van Denderen & van der Wolf, 2018; Drennan, 2019, 2020; Drennan, Harvey, Wood, Rong Cheng & Wood, 2018; van der Wolf et al., 2016). Moore (forthcoming) has articulated the links between restorative justice practice and current emerging trauma-informed mental health practice in the United Kingdom. This joins a growing body of literature within the restorative justice field of the links between trauma-informed practice and responses to harm (Christen-Schneider & Pycroft, 2021; Oudshoorn, 2015).

The above innovations to introduce restorative justice are being driven in England and Wales, and in Holland, by mental health practitioner developments. While there is a development of momentum to include restorative practice in forensic mental health settings, this tends to be in pockets and led by particular 'culture carriers'. Competence to offer restorative justice interventions to victims, in which the offender is a mental health service user, is not yet formally included in the service specifications of contracts with providers of restorative justice in the United Kingdom, and neither is this capacity included in the service specifications of mental health service providers. Without particular individuals, or small groups of individuals, holding a vision of what is possible, restorative justice in these settings would likely continue to be a largely theoretical possibility. We will now turn to the reasons that mental health settings may be slow to adopt these practices.

5 'Cultural' considerations in mental health settings

If the practice of offender rehabilitation in a mental health setting is viewed through the lens of 'culture', then it is important to understand the 'beliefs' and 'values' that are held most dear by the population. It is important to understand 'social structure' and 'hierarchy', and it is crucial to understand behavioural expectations and 'taboos'. If a restorative justice practitioner and restorative justice

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practices are to be tolerated in this 'cultural space', then the practices have to be compatible with cultural conventions and norms. The factors we consider here are not an exhaustive list but serve to illustrate particular features of 'the clinic' that are relevant to restorative justice practice. We have considered these in terms of the ethical requirements of a registered mental health practitioner, the ethical requirements of an intervention and the question of criminal responsibility of the offender.

5.1 Ethical Considerations

The initial consideration for restorative interventions is first and foremost an ethical requirement arising out of a duty of care. The principle of 'duty of care' is that a practitioner has an obligation to avoid acting, or failing to act, in such a way that the actions could be reasonably foreseen to injure or harm. This means that practitioners must anticipate risks and take care to prevent clients coming to harm. The first principle of medical ethics is beneficence: 'do no harm' (Beauchamp & Childress, 2001). If an intervention or a 'treatment' has not been shown to be 'safe' through established practice, a registered practitioner places themselves at risk of prosecution for negligence if someone should come to harm in their care while 'administering' an unproven intervention. This would place them in jeopardy of being struck off from their professional register and the loss of professional identity and that they would have on their conscience that someone came to harm as a result of their practice. This is not to suggest that restorative practitioners are not very alive to issues of safety and risk. The assessment of safety is fundamental to each step of a restorative process. However, restorative practitioners tend not to be required to maintain a legal or statutory registration in the same way as healthcare practitioners, and the voluntary nature of restorative interventions limits the extent of the practitioner's liability. However, the vulnerability of mental health service users and the power of the 'prescription' of an intervention by a registered practitioner introduce additional burdens of responsibility.

It is very likely that everyday restorative justice practice encounters some degree of mental health vulnerability when undertaken in criminal justice settings. Victims of offences have been harmed, and the alleviation of post-traumatic symptoms is one of the strongest evidence-based arguments for the offer of restorative justice interventions (Poulson, 2003; Hansen & Umbreit, 2018; Sherman, Strang, Mayo-Wilson, Woods & Ariel, 2015). Even so, restorative justice is not a treatment for post-traumatic stress disorder and cannot be prescribed for its alleviation. Similarly, the majority of offenders are likely to have varying degrees of mental health needs, but these will not usually be seen to interfere with their capacity to participate. In this way, mental health difficulties can be seen as a complication, or a 'responsivity' factor, when restorative justice is offered as a voluntary activity undertaken in a criminal justice setting with individuals who have the capacity to choose.

The expansion of restorative justice practice into 'the clinic' - in other words, medical settings - means there may be participants who are involuntarily detained under the mental health legislation of the jurisdiction. In such settings, mental capacity to consent to a treatment cannot be assumed and must always be explicitly

confirmed for interventions. This creates additional responsibilities for all practitioners. In the United Kingdom, all patients detained under the Mental Health Act (MHA 2003, as amended 2017) are under the care of a responsible clinician (RC). The role of the RC entails legal responsibilities and duties. Until recently, the RC was always a medical practitioner and consultant psychiatrist. There is now provision within the MHA for non-medical RCs who have been trained and accredited as approved clinicians and who may be qualified as nurses, psychologists, social workers, or occupational therapists. All interventions with a patient detained under the MHA, whether in hospital or in the community under a conditional discharge, require the approval of the RC to be initiated. At this point, the patient has the right to refuse, conditional on a formal assessment of their capacity, which is also governed by legislation. This places the RC in the position of responsibility but also power. An interview subject in Dwornik (2014) found that psychiatrists were happy to be guided by the restorative practitioner as to the suitability of their patient for the intervention. Our experience in forensic mental health settings has been more mixed. It is clear that the 'authority' rests with the RC to decide whether the patient can be approached regarding a restorative intervention, either because a victim has requested this, or because the characteristics of the offender or the nature of the offence suggests that the case may be suitable. The RC's judgement may be more or less well-informed regarding restorative justice and its evidence base, but their judgement is final. Some are open to negotiation and others are not. Some RCs are willing to be guided by the restorative justice practitioner, but at each stage of the process, the RC needs to be kept informed as to progress and developments.

However, mental healthcare is also mainly delivered by a multi-professional team (MPT) made up of nurses, social workers, psychologists, occupational therapists, and other practitioners. Most RCs consider the views of the MPT regarding interventions, their suitability, and their timing. In this way, most decisions are made corporately, even if the RC holds the ultimate responsibility and the power of veto. The forum for decision-making is the ward round or care review. The multi-professional group, who make up the care team of an inpatient, meets weekly or fortnightly to consider the progress of care. This invariably includes an interview with the patient. Any wish to consider or initiate a restorative intervention needs to be discussed in a care review (or ward round) and may, or may not, include a discussion with the restorative justice practitioner. Objections to the nature or timing of the intervention can come from anywhere in the MPT, and most interventions require the unanimous support of the team. This is often a complex negotiation in which issues of trust, insider/outsider status of the restorative justice practitioner, and the perception of the offender patient's motivation to engage are all at play.

There are some settings in which restorative justice is relevant to independent mental health practice; in other words, a practitioner working independently in the community to provide some form of mental health service to the general public. There is another set of considerations when the participants are community-based mental health service users and may not be under the care of an inpatient mental health team. In one case, the first author was approached to take on a victim-initiated

restorative justice case in which the victim had previous hospitalisations for mental health needs and significant offending behaviour themselves. However, the victim was not a registered service user with the first author's employing NHS service, and there was therefore no 'clinic' structure to support a restorative intervention. It would have been possible for the case to be progressed by the usual means, as is the case for so many restorative justice interventions, by volunteers for the provider organisation. As the victim was known to have mental health needs, the first author could have offered mental health consultation or supervision of the case workers. However, as the case workers themselves would not be mental health practitioners, it would be the registered clinician who would hold the 'duty of care' responsibility, should there be an adverse outcome that affected the well-being of the victim, or indeed, if the victim became destabilised and caused further harm to themselves or others. In such circumstances, careful thought would need to be given to the necessary governance structures that would be required to enable the intervention to take place in a safe and responsible way. This would need to be done in such a way that the clinician supporting the process was not themselves exposed to a negligence claim or a formal complaint to the relevant professional registration body.

What both the above clinical scenarios illustrate is that as soon as the mental health needs of the participants are formally recognised as being relevant to the governance of the intervention, clinical practitioners take on a greater degree of responsibility and accountability. The structures necessary for accountability and governance that protect the patient engaging in a restorative intervention as a 'patient', and the clinician endorsing that intervention as not clinically contra-indicated, cannot be taken for granted. The clinical factors relevant to restorative justice casework often need to be clarified as sufficiently robust on a case-by-case basis. An important principle of ethical clinical decision-making is the evidence base for an intervention.

5.2 Evidence-based practice

There can be few areas of mental health practice that value evidence-based practice more highly than in forensic mental health. There is a strong parallel between this field and the risk reduction and violence interventions offered in criminal justice settings, in which the evidence base of a programme must have been demonstrated in empirical research on outcomes for offenders (O'Brien, Sullivan & Daffern, 2016). The dominant paradigm for intervention programmes is the Risk-Needs-Responsivity (RNR) model of offender rehabilitation (Andrews & Bonta, 2010). The RNR model requires that resources are targeted according to the level of risk, where high-risk offenders should receive resource-intensive interventions, but low-risk offenders should not receive resource-intensive interventions, not least because that will direct resources away from high-risk offenders. The 'needs' element of the model requires that interventions should target what are referred to as 'criminogenic needs' before 'non-criminogenic' needs. This requires that attitudes and behaviours that support offending behaviour should be treatment 'targets' of greater priority than 'non-criminogenic' needs such as mental health. In fact, in the model, mental health needs are seen as a

'responsivity impediment', where responsivity refers to factors such as learning style of the offender. It is within the RNR paradigm that cognitive behavioural interventions have come to overwhelming prominence in the domain of offender interventions. The RNR model has been subject to critique (Ward & Maruna, 2007), and there are now competing models such as the 'Good Lives Model' (Ward & Fortune, 2013). However, other models do not yet have the evidence base to displace the dominance of the RNR model. There is a degree of latitude in forensic mental health as the evidence base is more difficult to establish and intervention programmes often require adaptation to be needs-led. Nevertheless, the current models of the rehabilitation of offender patients do not easily accommodate the restorative justice interventions as an evidence-based intervention for this group.

This reservation about the place of restorative justice in offender rehabilitation runs even more deeply. There is a strongly held view amongst many practitioners in offender rehabilitation that 'victim empathy makes no difference to reoffending' (Barnett & Mann, 2013). This view can be found to have generalised across all forms of offender rehabilitation and into forensic mental health rehabilitation as well, even though the roots of this view can be traced to the evidence from sex offender treatment programmes (Mann & Barnett, 2012). Sex offender treatment programmes (SOTP) were developed in the RNR paradigm in the 1990s and included the elements of the following 'victim empathy' components: the offender role-playing the victim; the offender writing an account of the offence from the victim's perspective and reading it aloud to the group; group members who were abused themselves saying how it affected them; reconstructions of the offence; reading accounts of victims or watching video accounts and meetings with abuse survivors. In a meta-analysis of cognitive behavioural therapy (CBT) programmes, Landenberger and Lipsey (2005, in Barnett & Mann, 2013: 290) found that

> Even if the manuals were uncontroversial, perhaps the programme therapists worked in a way that would increase shame, which is a particular risk with victim empathy intervention and which could impair rather than enhance the ability to empathise with others.

We argue that the 'victim empathy' components of programmes described above are fundamentally flawed in their delivery because they lack a restorative element. They appear to employ precisely what Braithwaite (1989) warned against, namely, the use of 'stigmatic' shaming, which increases shame and social exclusion, rather than 'reintegrative' shaming, as is strived for in restorative interventions. Nevertheless, these aspects of sex offender treatment programmes are typically rated as the second most important factor, or 'very important', second only to 'taking responsibility'. Mann & Barnett (2012) note, however, that "an unspecified number of participants … described intensely negative experiences of victim empathy work, using words like 'traumatising', 'shocking', 'heart-breaking', 'upsetting' and 'stressful' … 'a helpful but difficult process'" (ibid, p. 292). This review therefore indicated that victim empathy work is both rehabilitative and punishing. The implications for treatment programmes are that service users value victim empathy work, and so it cannot be dismissed entirely; but therapists should

be aware of ethical dilemmas that arise when administering interventions that appear to be 'greater good' forms of punishment, and finally, that victim empathy work is more prominent than is justified by the evidence.

This perception of the place of victim empathy is even more likely to be questioned in a mental health population in which the capacity to express and feel empathy can be impaired for the very clinical reasons that offences are committed (Farrow & Woodruff, 2007). Patients who suffer from conditions such as schizophrenia may have cognitive difficulties and disruptions in their ability to show the usual range of emotional expressions (so-called flattened affect); patients with severe depression and other related conditions may suffer from what is called 'morbid guilt' where they believe they are guilty of acts they have not committed; patients may have autism that impairs their emotional range of expression; and most have suffered severe childhood trauma, manifesting in complex trauma presentations in adulthood and what is referred to as 'fused shame and guilt' or 'toxic shame' (Lewis, 1971; Tangney & Dearing, 2002; Tangney, Stuewig & Martinez, 2014). These features of mental health difficulties need to be considered when assessing the offender patient for suitability for a restorative intervention. It is also important to prepare the victim participant that the offender patient may not respond emotionally or behaviourally in the ways that they are expecting and to not misread this as a lack of remorse or emotion (see Tapp et al., 2020 for an example of such preparation).

Dwornik (2014) notes that restorative justice has been referred to as 'a severe sort of justice' (p. 6). In vulnerable individuals, a highly emotionally impactful intervention that is designed to be 'shame-inducing' is a precarious one that can prompt alarm in clinicians who are committed to not increasing risk in their patients. Where interventions are likely to be emotionally challenging and potentially destabilising for a forensic patient, these are usually undertaken while the patient is in hospital and can benefit from the round-the-clock support from nursing staff. However, a potentially destabilising intervention that takes place when a patient has achieved a degree of stability in the community raises significant ethical questions, particularly if the risks of destabilisation are not only to the patient but also to the people who may be harmed if there is a re-offence (Drennan, Casado & Minchin, 2014).

5.3 Accepting responsibility

In the United Kingdom, most forensic patients detained under the criminal sections of mental health legislation have been convicted of an offence, and most have been found guilty with Diminished Responsibility. Some jurisdictions find people, for whom mental health difficulties played a material role in the commission of an offence, Not Criminally Responsible (NCR) or Not Guilty by Reason of Insanity (NGRI). An NGRI is a rare outcome in the United Kingdom. Such people must nevertheless be treated in hospital until it is deemed safe to release them. Our experience in the United Kingdom is that patients who have had a 'Diminished Responsibility' disposal are made anxious due to talk to promote engagement in restorative justice interventions that involves 'accepting responsibility' (Wood, 2019). The offender patients have expressed concerns that if they 'accept

responsibility', they may undermine the basis of their conviction and be returned to court. We have approached this difficulty with engaging the offender patient in restorative interventions by explaining that they need to be: 'accepting' that they committed the offence; 'capable' of recognising the harm caused, and 'willing' to make undertakings to reduce risk going forward. This crucial element of 'taking responsibility' going forward, for example, in the form of taking medication or avoiding substance misuse, is a state in which the patient is 'in recovery' from harm. Drennan (2018) has proposed a working definition of 'recovery from harm' as

> 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 (ibid, p. 192).

The converse of this can occur in relation to victims. In our experience, many victims dismiss the possibility of restorative justice interventions with the person who harmed them when they become aware of the offender's mental illness. By doing so, the victim may be dismissing the possibility of being provided with an account of what happened, the offender's motivations, and so forth, because of an idea that there was no reason for the harmful act, only the 'unreason' of mental illness. It is possible that victims in such circumstances could be encouraged to be future-oriented for their own benefit, rather than despairing of the 'looking back' process that is assumed in the idea of 'taking responsibility'.

6 A three-point plan of implementation

The following 'map' demonstrates how the development of restorative justice interventions in forensic mental health settings could progress using an aggregation of learning from what is already happening, showcasing best practices in forensic mental health, and envisioning what may be possible. This takes a 'generational approach'. In other words, with a fair wind, in a generation from now, mental health services may be in a more robust place when it comes to the introduction of restorative justice interventions. Without key culture carriers in early adopter sites, this work in the United Kingdom and elsewhere may be at risk of coming to a grinding halt.

6.1 Victim participation in forensic mental health services

The recovery movement has transformed mental health services. There has been nothing short of a paradigm shift in service user involvement, or peer participation in mental health services (Anthony, 1993; Deegan, 1988; Repper, Walker, Skinner & Ball, 2021; Roberts & Wolfson, 2004). Prior to the recovery movement, mental health services were based on a paternalistic model of care, in which the healthcare professional knew best, and the person with the illness was a passive subject in receipt of care. Indeed, this state of passivity in care is the origin of the word

'patient'. People in mental health services came to realise that they were neglecting an enormous resource that was already present: the human capital of the service user 'voice'. People who have engaged in a personal recovery journey have a voice that can speak to other people who are also confronted by the challenge of that journey, having walked in their shoes. This authenticity is something that has long been known in the Alcoholics Anonymous movement and in other self-responsibility paradigms. However, forensic mental health services have a dual rehabilitation task. Not only must they support the recovery of people from their mental health conditions, but they must also support the person who has caused harm as a result of their mental health condition to come to terms with what this means for their identity and their future life (Drennan & Alred, 2012; Dworkins & Adshead, 2011). Drennan (2018) makes the case that a greater level of victim participation in forensic mental health services has the potential to transform forensic mental health services much in the way service user participation has. This suggests that, as much as the peer 'voice' was missing from mental health services, the victim's 'voice' remains largely absent from forensic mental health services.

There is scope for victim representation in organisations that care for or rehabilitate offenders at many levels. By victim participation, we do not intend to mean 'the victim' of a specific offender patient, but rather people who have experienced harm as a result of the actions of people with mental health difficulties and who can represent their experience and perspective. Many 'victims' are carers, supporters, and family members. Good mental health services involve carers and family and are increasingly required to do so by quality standard networks and commissioners. What mental health services do less well is attend to the needs of family members and carers when they have been victimised by the person they care for. This is in spite of how widespread carer harm is, as is evidenced in the literature (Jeandarme et al., 2019). However, our intention here is to suggest that the social capital of families and carers should not simply be as carers and family, but 'carers and family who have been harmed'. If services were to attend to the needs of patients' family and carers through restorative interventions, alongside other people who have experienced harm, services would be better placed to fulfil their purpose and obligations to victims.

There are examples of offender rehabilitation programmes that make use of 'proxy' victims, such as the Sycamore Tree Programme (Anderson, 2018; Fourie & Koen, 2018), the Restore Programme (Adler & Mir, 2012) and the 'Silence the Violence' Programme (Minnaar, 2010). However, the Sycamore Tree Programme has only been delivered in one forensic mental health setting (Drennan, 2018; Harvey & Drennan, 2021), and other mental health rehabilitation programmes do not yet make use of the power of direct victim testimony in a restorative format. There is clearly considerable scope for the development of the victim 'voice' as a component of forensic mental health recovery programmes.

There is a further way in which restorative justice could find a foothold in forensic mental health services if the victim's 'voice' was given greater priority. The ethical dilemmas associated with approaching restorative justice interventions as a 'treatment' for offender patients outlined above are less urgent when the needs of victims are prioritised. If the needs and wishes of a victim who wanted to participate

in restorative justice were the primary focus, the ethical burden on the clinician who is asked to approve the contact with a patient under their care is reduced to the question of capacity to consent. This could be considered together with a secondary clinical judgement as to whether the patient's mental health is sufficiently robust to undertake what the victim has asked of them. This decision on the part of the RC would be further supported by the qualified restorative justice practitioner (Dwornik, 2014, Tapp et al., 2020). The judgement of capacity to consent and mental health resilience to participate would remain under constant review, but the ethical burden of the safety of a 'prescribed' intervention would be alleviated. In other words, if the focus of a restorative intervention was on the well-being outcomes of the victim, a 'main effect', and not on the rehabilitative benefits to the offender patient, any benefit for the offender patient would be secondary and a 'side effect'. Forensic mental health services have an obligation of protection to the public and an obligation to ensure as much as possible that the patient in their care does not cause further harm to the previous victim or to new victims. This is an ethical and moral duty that is intrinsic to the operation of services through risk assessment and risk management processes and through multi-agency working. However, if there was a requirement on forensic mental health services to enable access to restorative justice for victims, service providers would, for the first time, be required to acknowledge an ethical obligation to promote the recovery of victims processes. In other words, through restorative processes, forensic mental health services could work towards becoming a 'capable environment' and meeting the needs of victims. Such an approach by forensic mental health services could be a meaningful articulation of their obligations under the European Directives and Recommendations, Victim's Charter's and Victim's Codes, highlighted at the start of this article.

6.2 Multi-faceted integration of restorative practice into forensic mental health-care

The efforts of a small number of services to introduce access to restorative justice interventions in mental health settings have demonstrated that a spectrum of approaches is needed. Before it is possible to enable restorative justice interventions that involve formal conferencing (Zinsstag & Vanfraechem, 2012), there is a need to develop an understanding of the range of interventions that fall under the heading of restorative practice amongst service users and mental health staff. This invariably involves providing service user and mental health staff awareness training events, in which the benefits of a restorative approach to conflict and harm are promoted. The awareness events also need to include the 'how to' of restorative practice, with clear guidance and protocols about how to go about implementing restorative approaches in the clinical environment. This raises the question of the scale at which the programme seeks to gain an organisational foothold. One such project has focused on developing the concept of a 'restorative ward' (Cooper & Whittingham, in press). This project has been developed in a secure mental health service catering to the needs of mental health service users who have learning disabilities and autistic spectrum disorders. Cooper and Whittingham (in press) describe staff training and service user awareness of a

protocol for 'restorative conversations' as a response to incidents of harm on the ward, either between residents or between residents and members of staff, the use of 'circles' each morning that brings the residents and staff together, and the promotion of 'affective statements' when in highly charged encounters are important components of the 'Restorative Ward' model.

A number of the mental health services attempting to introduce restorative justice interventions in the United Kingdom have begun with training a cohort of staff as restorative justice conference facilitators, using the current 'script-based' approach to conferencing favoured by the Restorative Justice Council of England & Wales (Wachtel, O'Connell & Wachtel, 2012). This training has enabled an understanding amongst clinicians of how to identify, assess, prepare, and deliver restorative justice interventions in their settings. Awareness training for the wider mental health staff group in a facility in the concepts of restorative practice generally, and restorative justice specifically, has also been key to developing the capacity to enable participation. Awareness training can be delivered as a stand-alone event or integrated into other training. As there is already a considerable burden on mental health staff for mandatory training in the United Kingdom, there is reluctance in service management to mandate further training. Therefore, integrating awareness of restorative practice into existing mandatory staff training, such as Adult Safeguarding Training, or Managing Violence and Aggression training, has been an important innovation. The integration of restorative practice into Adult Safeguarding Action Plans, in which there is a set of actions designed to reduce or eliminate the future risk of harm, is an important organisational enabler of engagement, not least because a new resource to support the organisation's obligations is more likely to be seen as helpful rather than an imposition. Moore (2016) described how some instances of when patients are required to be separated for their own safety, referred to as 'incompatibilities', can be addressed through restorative practices, even in a high secure hospital setting. In future, we hope to see restorative practice integrated into the introduction of 'Just Culture' approaches to responding to patient safety incidents (Meadows, et al., 2005). These developments would enable the future development of 'restorative hospitals' or the 'restorative healthcare organisation'.

Another key strategy to introduce restorative practices into forensic mental health services is to develop ways in which these practices are integrated into rehabilitation programmes. This can be done through the development of Recovery College courses (Newman-Taylor, Stone, Valentine, Hooks, Sault, 2016), the adoption of existing victim awareness and restorative justice programmes as stand-alone interventions, the integration of restorative practices into interventions targeting emotion regulation skills, compassion-focused or trauma-informed programmes, and interventions targeted at violence reduction. Substance misuse programmes can, for example, introduce restorative practice components to raise awareness of the harm caused by supporting and enabling the supply of drugs, both on the victims of crimes committed to procure drugs, but also on the substance misuser's social network. The key to the successful integration of restorative practice is not to focus exclusively on the novelty, or burden, of

additional interventions, but on the integration of the restorative practices and restorative justice into existing programmes.

Early adopter services found that they developed links with third sector restorative justice providers to enable the provision of specialist interventions (see, e.g. Tapp et al., 2020). There are two main considerations here. Restorative justice practice in England and Wales is supported by the Restorative Justice Council (RJC). The RJC maintains practitioner registers for training course providers and for practitioners, and Practice Guidance is published and regularly updated. All forensic mental health cases are 'complex and sensitive' by the definition (RJC, 2020). Forensic mental health clinicians, even those that have received conferencing training, are not usually experienced enough to provide restorative justice conferences in such cases and, if they do, they require supervision by a registered Advanced Practitioner. A second factor that has significant resource implications is that mental health services are not resourced to reach out to victims in the community to undertake the necessary engagement and preparatory work. In some cases, there are confidentiality concerns when the mental health service provider liaises directly with the victim. However, mental health service resources are directed towards meeting the needs of their clients, and unless the victim is a family member or another mental health service user, there is no obligation, or even capacity, to engage with a victim. The mental health service's engagement directly with victims also presents information governance challenges. Patient records are seldom likely to be an appropriate place to store records of contacts, risk assessments, well-being assessments and so forth, with victims. This places a limit on the extent to which a mental health service can engage directly with victims, unless the service invests in an additional, secure data management system, of the type used by independent restorative justice providers.

Drennan and Swanepoel (n.d.) have described a layered model for the delivery of restorative justice practice in one mental health service. This begins with the foundation of awareness training and events for staff and patients, leading to 'victim awareness' rehabilitation interventions for service users; the promotion of conflict resolution on ward environments through restorative dialogues; the provision of 'conference-style' interventions to address harm between patients or between patients and staff; the provision of restorative conferencing for harmed family members facilitated by a clinician and a restorative justice practitioner; and finally, the enabling of restorative conferencing through engaging a third sector partner provider to work with a harmed member of the community and the harmer patient, with the support of a trained clinician working alongside and in partnership with the restorative justice practitioners. This layered model ranges from high-volume, low-intensity interventions (restorative practices) to low-volume, high-intensity interventions (restorative justice conferencing).

What enabled the development of the model described above was the innovation South London & Maudsley NHS Foundation Trust made in employing a full-time restorative justice practitioner. Mental health clinicians are employed to fulfil certain job roles, and the provision of a restorative justice service does not feature in this. Restorative practice is therefore undertaken by clinicians with an interest on an opportunistic basis and where their clinical task can be addressed by

a restorative justice intervention. However, this risks that other clinical service priorities will take precedence, and the capacity to provide restorative interventions may evaporate. Our experience has been that a dedicated role enables the work of restorative justice to be personified in an identified person. This reinforces the importance of and opportunity for restorative practice in the minds of staff and patients, promoting referrals and enabling reach across a number of clinical teams and services. A specialist and dedicated role allows for restorative interventions to progress beyond that of a hobbyist. However, no job profile for a restorative justice practitioner currently exists within the NHS in the United Kingdom. The work to create such a profile and a suite of supporting job roles is currently underway. A small number of services have also made substantial progress in implementing restorative practice through either employing a restorative justice practitioner, such as in a project-based role in Queensland, Australia (Michael Power, personal communication) or Kent & Medway NHS Trust adding restorative justice practice to an existing job role when the staff member has undertaken further training (Sarah Cooper, personal communication). However, these are exceptionally rare innovations, illustrating the extent to which restorative practice continues to be a Cinderella function within mental health services.

6.3 Integration of restorative justice awareness into the training of mental healthcare professionals

Our experience, and the experience of other mental health practitioners who promote restorative justice in their clinical settings, is that there is a tremendous appetite to learn about these approaches amongst students and trainees. In keeping with our view that the mainstreaming of access to restorative justice in mental health will be a generational task, it is important that openness and appreciation are raised amongst student cohorts who will go on to be the practitioners of the future. There are a small number of postgraduate psychology practitioner courses that offer teaching on restorative justice, but to our knowledge, there has been no formal teaching in nursing, occupational therapy, or psychiatry training courses. These latter professional groups are currently reached through case presentations at continuous professional development forums and conference papers. Case examples of restorative interventions that demonstrate 'soft' outcomes in single-case studies are an important tool in the armamentarium of the restorative practitioner. It is through teaching the next generation of mental health practitioners about how restorative justice is practiced, how restorative practices can enhance the safety and the quality of inpatient treatment environments and how the needs of victims and offenders can be safely met by restorative justice, that the opportunities for such benefits will become more likely to be realised.

Postgraduate professional trainings allow trainees to engage in service evaluation research that can begin to build an evidence base for restorative practice in mental health. In time this may lead to doctoral studies that evaluate developing and emerging practice using single-case study designs or qualitative methods. Cook et al. (2015) was one early example of a practitioner doctorate, while Dwornik (2014) notes her disappointment at finding a paucity of case examples for a

master's degree in social work at that time. Practice is currently too piecemeal and fragmentary to support a quantitative outcome study and falls far short of the gold standard randomised controlled trial studies described in Sherman et al. (2015) for restorative justice interventions in mainstream criminal justice settings.

7 Concluding remarks

In this article, we described mental healthcare systems and forensic mental healthcare specifically as a unique and distinct cultural context. The parameters set out here highlight similarities and differences in the application of restorative justice practices when compared to contexts that are not formal mental healthcare settings. The particular requirements of safe and ethical practice for clinicians serve as an inhibitor to engagement with restorative interventions for their clients, given the paucity of evidence-based practice of restorative justice interventions with mental health service users who have caused harm. The attitudes of senior clinicians towards restorative justice can be a 'trivialising' one – that restorative justice is best suited to misbehaving juveniles, or a 'terrorised' one – that it is a dangerous and potentially harmful form of 'severe' justice. Mental health service users too fear the retribution of the victims of their violence, and the undermining of the legal basis of their convictions on the basis of diminished responsibility, if they accept responsibility for having caused harm. We have attempted to outline remedies to these obstacles, the principal amongst them being the prioritisation of the needs of victims. A wholesale drive to introduce the voices of victims is the first cornerstone of a three-point plan proposed to introduce restorative justice practices into forensic mental health settings. The second component of a plan is a multi-faceted approach to raising awareness and providing interventions that can be targeted at the level of a mental health ward or on the larger canvas of a hospital or a region. The nature of the resources available will determine what approach is best suited to the local conditions. Finally, if restorative practice is to take root in forensic mental health services, a long-term view is needed. The seeds of aspiration to see restorative justice made available to all victims and offender patients will need to be sown in the next generation of clinical practitioners through teaching and training in the academy.

References

Adler, J. R. & Mir, M. (2012). *Evaluation of the forgiveness project within prisons*. Middlesex University's Research Repository. Retrieved from https://eprints.mdx.ac.uk/9401/ (last accessed 19 November 2021).

Anderson, J. (2018). Introducing and theorising an in-prison restorative justice programme: the second-generation Sycamore Tree Project. *The International Journal of Restorative Justice*, 1(2), 210-229.

Andrews, D. A. & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence: Matthew Bender.

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23. doi: 10.1037/h0095655.

Babiak, P., Neumann, C. S. & Hare, R. D. (2010). Corporate psychopathy: talking the walk. *Behavioral Sciences and the Law*, 28, 174-193. doi: 10.1002/bsl.925.

Barnett, G. & Mann, R. E. (2013). Empathy deficits and sexual offending: a model of obstacles to empathy. *Aggression and Violent Behavior*, 18(2), 228-239. doi: 10.1016/j.avb.2012.11.010.

Beauchamp, T. L. & Childress, J. F. (2001) *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.

Braithwaite, J. (1989). *Crime, shame and reintegration*. Cambridge: Cambridge University Press.

Christen-Schneider, C. & Pycroft, A. (2021). An exploration of trauma-informed practices in restorative justice: a phenomenological study. *The International Journal of Restorative Justice*, 4(2), 229-252.

Cleckley, H. (1941). *The mask of sanity; an attempt to reinterpret the so-called psychopathic personality*. St. Louis: Mosby.

Cook, A. (2019). Restorative practice in a forensic mental health service: three case studies. *Journal of Forensic Psychiatry & Psychology*, 30(5), 876-893. doi: 10.1080/14789949.2019.1637919.

Cook, A., Drennan, G. & Callanan, M. M. (2015). A qualitative exploration of the experience of restorative approaches in a forensic mental health setting. *Journal of Forensic Psychiatry and Psychology*, 26(4), 510-531. doi: 10.1080/14789949.2015.1034753.

Cooper, S. L. & Whittingham, L. (in press). Victimisation experiences of individuals with autism spectrum disorders and restorative practice approaches to repairing harm. In N. Tyler & A. Sheeran (eds.), *People with Autism in the criminal justice and forensic mental health system: a handbook for practitioners*. London: Routledge.

Cooper, S., Drennan, G, Tapp, J., van Denderen, M. & van der Wolf, M. (2018). *Symposium: developments in the implementation of restorative justice approaches in forensic mental health*. International Association of Forensic Mental Health Services Conference, Antwerp, 11-15 June 2018.

Council of Europe (2018). *Recommendation CM/Rec(2018)8 of the Committee of Ministers to member states concerning restorative justice in criminal matters*. Retrieved from https://search.coe.int/cm/Pages/result_details.aspx?ObjectId=09000016808e35f3 (last accessed 28 September 2021).

Deegan, P. E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19. doi: 10.1037/h0099565.

Drennan, G. (2014). Restorative practice in forensic mental health. *Resolution*, Issue 51, Spring 2014.

Drennan, G. (2019). Psychotherapeutic change & restorative justice in dialogue. *Restorative justice council annual conference: beyond the mainstream*, Nottingham, 18 November 2019.

Drennan, G. (2020). Restorative Practice applications in mental health settings: pathways to recovery and restitution. *Royal Borough of Greenwich restorative approaches conference: finding humanity after hate – exploring restorative responses to serious violence*, Greenwich, 14 February 2020.

Drennan, G. (2018). Restorative justice applications in mental health settings – pathways to recovery and restitution. In J. Adlam, T. Kluttig & B. X. Lee (eds.), *Violent states and*

creative states: from the global to the individual. Book II: human violence and creative humanity (pp 181-194). London: Jessica Kingsley Publishers.

Drennan, G. & Alred, D. (2012). *Secure recovery: approaches to recovery in forensic mental health settings*. London: Routledge.

Drennan, G., Casado, S. & Minchin, L. (2014). Dilemmas and ethical decision-making: reflective practice in community settings. In R. Shuker & Z. Ashmore (eds.), *Forensic practice in the community* (pp. 40-60). London: Routledge.

Drennan, G., Cook, A. & Kiernan, H. (2015). The psychology of restorative practice in forensic mental health recovery. In T. Gavrielides (ed.), *The psychology of restorative justice* (pp. 105-120). Farnham: Ashgate Publishing.

Drennan, G. & Cooper, S. (2018). Restorative practice in mental health – gathering momentum. *Resolution*, (63, Autumn), 12-13.

Drennan, G., Harvey, J., Wood, F., Rong Cheng, L. & Wood, F. (2018). Implementation of a group-based restorative justice programme in an inpatient setting – participant outcomes and programme evaluation. *International Association of forensic mental health services conference*, Antwerp, Belgium, 23rd-26th June 2018.

Drennan, G. & Swanepoel, F. (n.d.). *The restorative circle: a model of implementing restorative justice practice in a mental health service*. Unpublished Manuscript.

Dworkins, E. & Adshead, G. (2011). Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment*, 17, 178-187.

Dwornik, A. (2014). *Restorative justice and mental illness: combating the 'spider syndrome'*. Unpublished dissertation, Vancouver: University of British Columbia.

European Forum for Restorative Justice. (2021). *Position paper on the evaluation of the restorative justice provisions of the victims' rights directive*. Retrieved from https://www.euforumrj.org/sites/default/files/2021-10/European_Forum_for_Restorative_Justice-evaluation_of_RJ_in-the_VRD.pdf (last accessed 19 November 2021).

Farrow, T. & Woodruff, P. (2007). *Empathy in mental illness*. Cambridge: Cambridge University Press.

Fourie, M. E. & Koen, V. (2018). South African female offenders' experiences of the Sycamore Tree Project with strength-based activities. *International Journal of Restorative Justice*, 1(1), 57-80. doi: 10.5553/IJRJ/258908912018001001004.

Garner, S. G. & Hafemeister, T. L. (2003). Restorative justice, therapeutic jurisprudence and mental health courts: finding a better means to respond to offenders with a mental disorder. *Mental Health Law*, 22, 1-15.

Gavrielides, T. (Ed.) (2021). *Routledge international handbook of restorative justice*. Oxford: Routledge.

Government of Ireland (2020). *Victim's charter*. Retrieved from https://www.victimscharter.ie/ (last accessed 27 October 2021).

Hafemeister, T. L., Garner, S. G. & Bath, V. E. (2012). Forging links and renewing ties: applying the principles of restorative and procedural justice to better respond to criminals with a mental disorder. *Buffalo Law Review*, 60, 147-223.

Hansen, T. & Umbreit, M. (2018). State of knowledge: four decades of victim offender mediation research and practice: The evidence. *Conflict Resolution Quarterly*, 36, 99-113. doi: 10.1002/crq.21234.

Hare, R. D. (2003). *The hare psychopathy checklist–revised* (2nd ed.). Toronto: Multi-Health Systems.

Harvey, J. & Drennan, G. (2021). Performing Restorative Justice: Facilitator experience of delivery of the Sycamore Tree Programme in a forensic mental health unit. *The International Journal of Restorative Justice*, 4(3), 420-438. www.elevenjournals.com/tijdschrift/TIJRJ/2021/Online%20First/TIJRJ-D-21-00002.

Jeandarme, I., Vandenbosch, L., Groenhuijsen, M., Oei, T. I. & Bogaerts, S. (2019). Who are the victims of NGRI acquittees? A study of Belgian Internees. *Violence and Victims*, 34(3), 434-451. doi: 10.1891/0886-6708.VV-D-16-00197.

Johnstone, G. & Van Ness, D. W. (eds.) (2011). *Handbook of restorative justice*. Oxford: Routledge.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lilienfeld, S. O. & Andrews, B. P. (1996). Development and preliminary validation of a self-report measure of psychopathic personality traits in noncriminal population. *Journal of Personality Assessment*, *66*(3): 488-524. doi: 10.1207/s15327752jpa6603_3.

Mann, R. E. & Barnett, G. D. (2012). Victim empathy intervention with sexual offenders: Rehabilitation, punishment or correctional quackery? *Sexual Abuse: A Journal of Research and Treatment*, 25(3), 282-301. doi: 10.1177/1079063212455669.

Meadows, S., Baker, K. & Butler, J. (2005). The incident decision tree: guidelines for action following patient safety incidents. In K. Henriksen, J. B. Battles, E. S. Marks, et al., (eds.), *Advances in patient safety: from research to implementation* (Vol. 4: Programs, Tools, and Products). Rockville: Agency for Healthcare Research and Quality (US). Retrieved from www.ncbi.nlm.nih.gov/books/NBK20586/ (last accessed 19 November 2021).

Ministry of Justice. (2020, November). *Code of practice for victims of crime in England and Wales*, London: MoJ. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974376/victims-code-2020.pdf (last accessed 27 October 2021).

Minnaar, N. (2010). Silence the violence. *Journal of Aggression, Conflict and Peace Research, 2*(1), 69-72. doi: 10.5042/jacpr.2010.0006.

Moore, E. (2016). Broadmoor hospital's restorative journey. *Resolution*, (57, Spring 2016).

Moore, E. (forthcoming). Trauma and restorative justice. In P. Willmot & L. Jones (eds.), *Trauma-informed forensic practice*. Oxford: Routledge.

Moore, E. & Kiernan, H. (2017). Broadmoor hospital's restorative journey. *Resolution*, (61, Autumn 2016).

Moore, E. & Simon, J. (2019). Restorative practices in mental health 2019: seminar up-date. *Resolution*, (65, Autumn), 15.

Newman-Taylor, K., Stone, N., Valentine, P., Hooks, Z. & Sault, K. (2016). The recovery college: a unique service approach and qualitative evaluation. *Psychiatric Rehabilitation Journal*, 39(2), 187-190. doi: 10.1037/prj0000179.

O'Brien, K., Sullivan, D. & Daffern M. (2016). Integrating individual and group-based offence-focussed psychological treatments: towards a model for best practice. *Psychiatry, Psychology and Law*, 23(5), 746-764. doi: 10.1080/13218719.2016.1150143.

Oudshoorn, J. (2015). Trauma-informed rehabilitation and restorative justice. In T. Gavrielides (ed.), *The psychology of restorative justice* (pp. 159-182). Farnham: Ashgate Publishing.

Poulson, B. (2003). Third voice: a review of empirical research on the psychological outcomes of restorative justice. *Utah Law Review*, 15(9), 167-204.

Power, M. (2017). *The Dorothy and Brian Wilson Churchill Fellowship to research innovations for improving the lives of victims of serious violence committed by people with a mental illness – USA, Canada, UK, The Netherlands*. Retrieved from www.churchilltrust.com.au/fellows/detail/4195/Michael+Power (last accessed 19 November 2021).

Quinn, J. & Simpson A. I. F. (2013). How can forensic systems improve justice for victims of offenders found not criminally responsible? *Journal of American Academy Psychiatry Law*, 41, 568-574.

Repper, J., Walker, L. Skinner, S. & Ball, M. (2021). Preparing organisations for peer support: Creating a culture and context in which peer support workers thrive. *ImROC Briefing Paper No. 17*. Retrieved from https://imroc.org/resources/preparing-organisations-for-peer-support/ (last accessed 19 November 2021).

Restorative Justice Council. (2020). *Restorative practice guidance*. Norwich: RJC.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, 10(1), 37-48. doi: 10.1192/apt.10.1.37.

Sherman, L. W., Strang, H., Mayo-Wilson, E., Woods, D. J. & Ariel, B. (2015). Are restorative justice conferences effective in reducing repeat offending? Findings from a Campbell Systematic Review. *Journal of Quantitative Criminology*, 31(1), 1-24. doi: 10.1007/s10940-014-9222-9.

Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998) *Psychiatric morbidity among prisoners in England and Wales: summary report*. London: Office for National Statistics.

Sullivan, D. & Tifft, L. (eds.). (2007). *Handbook of restorative justice: a global perspective*. New York: Routledge.

Tangney, J. P. & Dearing, R. (2002). *Shame and guilt*. New York: Guilford Press.

Tangney, J. P., Stuewig, J. & Martinez, A. G. (2014). Two faces of shame: the roles of shame and guilt in predicting recidivism. *Psychological Science*, 25(3), 799-805. doi: 10.1177/0956797613508790.

Tapp, J., Moore, E., Stephenson, M. & Cull, D. (2020). 'The image has been changed in my mind': a case of restorative justice in a forensic mental health setting. *The Journal of Forensic Practice*, 22(4), 213-222. doi: 10.1108/JFP-05-2020-0023.

Thomas, E. C., Bilger, A., Wilson, A. B. & Draine, J. (2019) Conceptualizing restorative justice for people with mental illnesses leaving prison jail. *American Journal of Orthopsychiatry*, 89(6), 693-703. doi: 10.1037/ort0000316.

Tyler, N., Miles, H. L., Karadag, B. & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social Psychiatry & Psychiatric Epidemiology*, 54, 1143-1152. doi: 10.1007/s00127-019-01690-1

United Nations Office on Drugs and Crime. (2020). *United Nations Handbook of Restorative Justice*. Vienna: United Nations.

van Denderen, M. Y., Bax, R. & Sweers, N. (2016). *Contact tussen slachtoffer/nabestaande en tbs-er: Een Richtlin voor Forensisch Netwerkbegeleiders in Forensisch Psychiatrische Centra*. Retrieved from https://files.enflow.nl/fd9938a8-0039-4987-aee4-d3773cabfd43/c3fe5633-659c-46d0-b624-70920d1cd024/projecten/call-2013-13-richtlijn-definitief.pdf (last accessed 19 November 2021).

van Denderen, M., Verstegen, N., de Vogel, V. & Feringa, L. (2020). Contact between victims and offenders in forensic mental health settings: an exploratory study. *International Journal of Law and Psychiatry*, 73, 101630. doi: 10.1016/j.ijlp.2020.101630.

van der Wolf, M., Blad, J., Wood, F., van Denderen, M., Sweers, N., & Bax, R. (2016). Symposium: Restorative Justice and Mentally Disordered Offenders: Theory and Practice. *Realising Restorative Justice: Human rights and personal realities. The 9th international conference of the European forum for restorative justice*, 22-24 June 2016, Leiden, The Netherlands.

Viding, E. (2019). *Psychopathy: a very short introduction*. Oxford: Oxford University Press.

Wachtel, T., O'Connell, T. & Wachtel, B. (2012). *Restorative justice conferencing*. Pipersville: The Piper's Press.

Ward. T. & Fortune, C-A. (2013). The good lives model: aligning risk reduction with promoting offenders' personal goals. *European Journal of Probation*, 5(2), 29-46. doi:10.1177/206622031300500203.

Ward, T. & Maruna, S. (2007). *Rehabilitation*. Abingdon: Routledge.

Wood, F. (2019). The Restorative Circle @ SLaM: Creating mental space for health-based practice. *Restorative justice council annual conference: beyond the mainstream*, Nottingham, United Kingdom, 18 November 2019.

Zinsstag, E. & Vanfraechem, I. (eds.) (2012*). Conferencing and restorative justice: international practices and perspectives*. Oxford: Oxford University Press.