ARTICLE

The spaces for restorative justice practices in a forensic inpatient mental health hospital: a thematic analysis of group case supervision.

*James Tapp and Chelsea Verrinder**

Abstract

Restorative justice practices are relatively new to forensic mental health settings. Therefore, there is limited understanding of where and how these practices might feature in this work. The current study explored the spaces for them in a forensic inpatient hospital drawing upon data from group case supervision. Five themes were developed from three concurrent monthly case supervision sessions attended by fourteen restorative justice practitioners. Challenges to using restorative justice practices where participants had mental health needs were evident, but these needs were not thought to preclude their use. Practitioners brought up implications for workload. Assumptions about the principle of neutrality were raised, where staff had different roles in the process. Staff as participants in restorative justice practices raised considerations around professional identity and vulnerability. Restorative justice practices offered unique and complementary ways to repair harm, but these may not always fit within the values or needs of the organisation. The idea of bringing together people affected by harm can raise worries and may feel counter-intuitive to practices that reduce risk. It was important that new staff were made aware of restorative justice opportunities and that policies and procedures were in place and communicated to protect and foster its new status.

Keywords: restorative justice, secure, forensic, inpatient, mental health, implementation.

1 Introduction

Restorative justice is a term that has been used to refer to practices aimed at repairing harm between people. Its origins are thought to be in a range of traditions and teachings, with the common focus on justice. This has included within

* James Tapp, PhD, is a Senior Lecturer at Kingston University, London, United Kingdom and psychologist at Broadmoor Hospital in Crowthorne, United Kingdom. Chelsea Verrinder is a Nurse Degree Apprentice at Broadmoor Hospital in Crowthorne and Buckinghamshire New University, United Kingdom.
Corresponding author: James Tapp at james.tapp@westlondon.nhs.uk.

Aboriginal, Inuit and Christian faith communities and Buddhist, Taoist and Confucian philosophies (Braithwaite, 2002). From these roots, restorative justice has been defined and commuted across many different countries and contexts (Daly & Immarigeon, 1998; Leung, 1999). At a macro level, it has been described as a grassroots movement in response to social inequalities, while at a micro level as a conversation between two people about harmful actions. The spectrum of restorative practices that represents restorative justice makes it a broad church, although it has also meant that a common definition of restorative justice as a philosophy and its practices has been difficult to reach agreement on (Daly, 2016). One arena that it would expectedly feature in, given the objective of repairing harm, is criminal justice work. The most cited example of restorative justice first being used is the Kitchener experiment in Ontario, Canada, in the 1970s; a victim-offender reconciliation programme that was delivered in collaboration with a probation service (McCold, 1999). The process of bringing together people who have been affected by harm with those that caused it to discuss its impact and how to move forward, aligned with what restorative justice can represent (Marshall, 1999). Since this introduction, restorative justice has been adopted into different corners of criminal justice settings across the world (van Ness, 2001). Examples of such practices have been as a community policing strategy to divert young people from court, working with young people who were from disadvantaged families, restructuring police cautions, a response to domestic violence and restorative programmes delivered in prisons (van Ness, 2005). One area of criminal justice work where restorative justice has seemed to be slower in gaining a foothold is forensic mental health services (Drennan, Cook & Kiernan, 2015). These services are provided worldwide, albeit with some variations in task and approach (Taylor et al., 2014). Given the context of the current study, the United Kingdom (UK) provision is described here. Services are provided in the community and in low, medium and high secure hospitals. Their broad function is to understand (assess) and treat people who have caused harm to others and who have been diagnosed with some form of mental disorder(s) thought to contribute to their risk of harm (NHS England, 2021). In addition to acts of harm that warrant contact with forensic mental health services, incidents of harm also occur while people are with these services; so opportunities for restoration exist (Barabás, Fellegi & Windt, 2012).

1.1 Restorative justice initiatives in forensic mental health settings

The different ways in which restorative justice has been introduced in this field have been synthesised in recent reviews (see Harwood, 2020; Martin, Kenzie, Campbell & Bickle, 2022). In Australia, Queensland, a Victim Support Service has developed a programme of restorative practice linked with a secure mental health rehabilitation service (Power, 2017). The programme focuses on harm that happens between patients, staff and carers as well as any historical harm, before admission. In America, restorative justice initiatives have been tried in juvenile mental health courts (Quinn & Simpson, 2013). In Canada, an outpatient service has taken a restorative approach to working with families of forensic patients where harm has happened within the family. In the UK, restorative justice has been introduced in

community and forensic mental health hospital, across the different security levels (low, medium and high). Applications have included developing restorative wards, repairing harm within and outside the hospital environment, managing conflict between staff within the workplace and the use of art workshops for exploring the idea of reparation (Cook, Drennan & Callanan, 2015; Drennan & Cooper, 2018; Drennan & Swanepoel, 2022; Kaur, de Boer, Oates, Rafferty & Dekker, 2019). Finally, in the Netherlands, there has been a focus on contact between patients detained in forensic inpatient hospitals and people in the community who had been harmed by them (van Denderen, Verstegen, de Vogel & Feringa, 2020).

1.2 The compatibility between restorative justice and forensic mental health work

The reasons why restorative justice has not historically been used in forensic mental health settings is unknown. Its absence has been said to be counter-intuitive given that there are clear overlaps between the purpose and practices of the therapeutic functions of these services and those of restorative justice (Drennan, 2014). Furthermore, ideas that have been incorporated into forensic mental health ways of working, such as enabling environments (Haigh, Harrison, Johnson, Paget & Williams, 2012) and Safewards (Bowers, 2014), contain principles and objectives that are familiar to those of restorative justice. For example, Safewards focus on managing and resolving conflict, and enabling environments aim to include opportunities for people to discuss feelings behind the way people act. Similarly, recovery-based practices and trauma-informed care have been said to parallel those of restorative justice (Cook, Drennan & Callanan, 2015; Oudshoorn, 2015). Additionally, restorative justice outcomes research from other criminal justice settings, while not necessarily directly transferable, points to broad evidence of benefit with people in criminal justice systems (e.g. Bradshaw & Roseborough, 2005; Latimer, Dowden & Muise, 2005; Sherman et al., 2005). It has also been argued from theoretical and legislative perspectives that restorative justice would be well placed in forensic mental health environments (Garner & Hafemeister, 2003; Hafemeister, Garner & Bath, 2012; Strang & Sherman, 2003).

1.3 Restorative justice and potential incompatibility

Just as there are facets of forensic mental health work that seem to 'fit' with restorative justice, there are also elements of the 'institutional DNA'[1] that may not. As 'total institutions',[2] they have been said to remove agency, responsibility and identity from people detained in them, including dissolving connections with the outside world (Goffman, 1968; Markham, 2021). In contrast, restorative justice practices assume people can take responsibility for harm they have caused, make amends and reintegrate into communities (Kirkwood, 2021). An institutional reflex of increasing restrictions and control when risk is high may be necessary in

1 The unique traits of an organisation, including decision rights, information, motivators and structure (Neilson, 2006).

2 'A place of residence where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life' (Goffman, 1969: 11).

the short (and even long) term, but moving from defensive to restorative practices will arguably be required for a person to be able to take responsibility for their actions (Roberts, Dorkins, Wooldridge & Hewis, 2008). The notion of bringing people together when harm has happened may feel less safe or uncertain than if they were kept apart and may also raise considerations around professional ethics and responsibilities to both those that caused harm and those harmed. Professional worries have been voiced about how to include people who have been harmed in the core task of forensic mental health work and whether including them may be at odds with the therapeutic environment of a hospital, if restorative justice elicits difficult emotions (Victims' Commissioner, 2018). This concern carries some validity in that a range of emotional experiences can feature in restorative justice practices such as shame, guilt, remorse, revenge, forgiveness and anger (Karstedt & Rossner, 2019). A further issue around the accountability of actions for forensic patients is the context in which harm took place and the language used to understand why. Legal and medical discourses around mental capacity and intent may inform views about whether a person can be held to account and take responsibility (Drennan et al., 2015). *Psycho-medical language* also refers to certain symptoms and deficits that could impact on a person's ability to access and understand emotions in themselves and others and that would have implications for the reparative interactions that can take place in restorative justice (Rossner, 2011). Case evidence provides one example where the impact of mental health on a person's capacity to remember the events of an offence informed a decision *not* to pursue restorative justice (Liebmann, 2007). In this case example, a person was convicted of the murder of their partner. The harmer expressed remorse for their actions and wanted to let those affected know this. A referral was made via a probation service victim liaison officer. The process included a meeting with the harmer and those affected. At the point of a second visit with the harmer, mental health issues were thought to have impacted on how the harmer recollected the harm caused, and mediators decided not to pursue a meeting. Similarly, the efforts to introduce restorative initiatives in juvenile courts in America were unsuccessful, as the young people were deemed too unwell to take responsibility or communicate (Quinn & Simpson, 2013).

1.4 The gaps for restorative justice in forensic mental health settings: might it 'fit'?

The antithetical positions (which are arguably oversimplified, Daly, 2002) on how restorative justice might 'fit' into a forensic mental health environment signpost both potential and challenges. Given its new emerging status, there is an opportunity to explore how restorative justice happens in this context and to provide insights into its (in)compatibility and scope for this type of setting. This may uncover lessons learnt that can guide further attempts of institutionalising restorative justice in such places. Perhaps more importantly, understanding how restorative justice takes place alongside the culture, goals, priorities and politics of such services is necessary to consider how this fit may influence its reach, as has been demonstrated from its introduction into other criminal justice settings (Crawford, 2006; Edwards, 2015; Marder, 2020). Observations and reflections from efforts to institutionalise restorative justice, while limited in number, with

only a few known examples from forensic mental health settings, highlight some common experiences. Restorative justice innovations tend to be championed and carried out by a small group of 'moral entrepreneurs'[3] by their nature of attempting to challenge the 'institutional DNA' with alternative approaches (Marder, 2016). At the highest level this may involve efforts to reconcile restorative justice and retribution paradigms (Gavrielides, 2014), which has been thought to cause mistrust and suspicion about restorative justice in the system (Zehr, 1994). When restorative justice happens, those that take part (facilitating and participating) may have to step into different roles, responsibilities or even identities. For professionals as facilitators, this may mean having to try and move from a position of authority or expert to one of neutrality and impartiality (Clamp & Paterson, 2013; Cook et al., 2015). For professionals, participating in restorative justice, as the harmed, may lead to communicating vulnerabilities and emotions that might not normally be shared (Cook et al., 2015; Harvey & Drennan, 2021). For those detained in criminal justice settings, including forensic hospital, engaging with restorative justice could require building a moral identity[4] that may be at odds with a prison culture (Guidoni, 2003).

These findings are partially aligned with some of the compatibility issues previously discussed, which may have implications for the embedding and fidelity of restorative justice in forensic mental health settings. However, some precautions warrant highlighting. For example, experiences of restorative justice implementation in prisons may not necessarily materialise in forensic hospitals, given that there is an ideological difference between the two (Gunn, 2000). Similarly, other criminal justice settings that have introduced restorative justice are likely to have nuanced cultures, goals, priorities and politics. The emerging research on restorative justice being delivered in forensic hospitals has explored how it fits in such places (Cook et al., 2015; Harvey & Drennan, 2021; van Denderen et al., 2020). The current study aims to contribute to this new area of inquiry by exploring the experiences of restorative justice practitioners delivering restorative justice in a forensic hospital setting. It makes a novel contribution to existing research, which has to date been based on interview methods, by 'inquiring' about restorative justice fit through observing and interpreting restorative justice practitioners' discussions in group case supervision.

2 Method

2.1 Design

The study took a constructivist inquiry approach to explore the supervision discussions of restorative justice facilitators undertaking restorative justice referrals within a forensic mental health service in the UK. Constructivist inquiry is a form of inquiry that focuses on how people make sense or meaning of their

3 Individuals, groups or organisations that seek to influence/reform ideas within the criminal justice system (Clairmont, 2011).

4 *Moral identity* refers to a person's perception of how important moral qualities are to their self-concept (Hardy & Carlo, 2005).

experiences, because of interacting with other people. Therefore, it is a means of inquiry that considers people's experiences in context-bound settings (Lincoln, 2007; Lincoln & Guba, 1985). This approach was taken because it was assumed that there would be different experiences and perceptions as to how restorative justice 'fitted' in the setting, and these could be shaped by values, for example individual and organisational. The approach chosen to access and interpret these was to study them in the context in which they occurred rather than applying a predetermined or specific line of inquiry or set of questions. It was also assumed that the interpretations of the discussions in group case supervision would be similarly shaped by the researcher's position and values, particularly as the first author was a participant observer, being an attendee of the group supervision session and a restorative justice facilitator.

2.2 Participants

Participants consisted of fourteen forensic mental health professionals working at a UK National Health Service (NHS) forensic inpatient hospital who were trained restorative justice practitioners. These included the first author. Practitioner training for staff was delivered over four days. The training for all staff included an introduction to the concepts and philosophy of restorative justice; information on formal and informal restorative processes, including conferences, with role-play practices, and, finally, a presentation of relevant national standards, including practitioner competency frameworks. Training content corresponded to the Restorative Justice Council standards for facilitator training (Restorative Justice Council, 2016). All practitioner cohorts were trained by a restorative justice practitioner who was not employed at the study site. The same practitioner also acted as an external consultant who attended the group case supervision sessions that were used in the current study. Details of participants who attended the supervision are provided in Table 1.

Table 1 ***Restorative justice supervision attendees***

Participant pseudonym	Professional role		Meeting 1	Meeting 2	Meeting 3
Teri	Assistant Psychologist	No	x	x	Y
Robin	Clinical Nurse Specialist	Yes	Y	x	x
Andy	Psychologist	Yes	Y	Y	Y
Riley	Clinical/Forensic Psychologist	Yes	x	x	Y
Kenzie	External Supervisor	Yes	Y	Y	x
Jo	Clinical/Forensic Psychologist	Yes	Y	x	x
Alex	Psychological Well-being Facilitator	Yes	Y	Y	Y

Table 1 (Continued)

Participant pseudonym	Professional role		Meeting 1	Meeting 2	Meeting 3
Harper	Forensic Psychologist	Yes	Y	Y	x
Blair	Chaplain	Yes	x	Y	Y
Frankie	Lead Nurse Therapist	Yes	Y	x	x
Jaime	Forensic Psychologist	Yes	Y	x	x
Reese	Clinical Psychologist	Yes	Y	x	x
Jesse	Psychological Well-being Facilitator	Yes	Y	Y	x
Jordan	Clinical Nurse Specialist	Yes	Y	x	x
Quinn	Clinical Psychologist	Yes	x	Y	Y

2.3 Study setting

The study setting was an NHS high-security forensic inpatient hospital in the UK. The service provides treatment for adults aged 18 years and over with mental disorders, including mental illness, personality disorder and neurodevelopmental disorders. Patients in this setting are detained under the Mental Health Act (1983) and typically have complex chronic mental disorders that are linked to serious harmful behaviour that warranted their admission. The hospital provides 210 beds. At the time of the study, the average age of patients was 40 years and the average length of stay 5.7 years. Patients stated a range of ethnicities: Asian or Asian British (1.5 per cent); Black British, Black Caribbean or Black African (28 per cent); White British or White European (50.8 per cent). Most patients had a primary diagnosis of schizophrenia (61.4 per cent), followed by personality disorder (28 per cent), and then other mental health diagnoses: mental and behavioural disorders due to psychoactive substance use (6.8 per cent) and mood disorders (2.3 per cent).

2.4 Procedures

The study procedures were reviewed and approved through a governance committee based at the study site. As the research involved NHS staff, it did not require Research Ethics Committee approval (Department of Health, 2018). Attendees at group case supervision sessions were informed of the study at the start of the session, and consent was sought to audio record the supervision. A digital recorder was used to promote the accuracy of the documented content for analysis. The supervision meetings were structured by an agenda that included updates and discussions about the status of existing referrals, new referrals and allocation of these and procedural/governance matters relevant to referrals. A total of three

one-hour-long group supervision sessions over three consecutive months were recorded. Audio files were then transcribed, and any identifiable information such as names of supervision meeting attendees, referred patients/staff and services were removed to anonymise transcripts.

2.5 Group supervision cases

Referrals for restorative justice could be received by any person within the service who was affected by harm, including staff and patients. Referrals could also come from restorative justice providers in the community where people living in the community had been harmed by patients who were admitted to the service. For referrals involving patients, a procedure applied whereby the patient's clinical team would be included in the decision-making around patient capacity and safety to take part in the restorative justice process. Referrals would be discussed during the group supervision sessions and then allocated to two restorative justice practitioners. The allocated practitioners would first meet separately with all parties involved and explore their hopes and motivations and expectations for engaging in restorative justice. This process could involve multiple sessions before either direct (i.e. conference) or indirect (i.e. letter exchange) contact took place. If the person(s) harmed or harmer(s) did not feel ready to engage in the restorative justice process, referrals were closed. Some restorative work could still take place with individuals wishing to take the process as far as possible. For example, a harmer may write a letter that did not get sent. This was aimed at enabling them to take responsibility and consider the harm caused, despite this not ending in a formal conference between stakeholders. Group supervision was held monthly to discuss new referrals and ongoing cases. Facilitators were supported to reflect on the progress of the restorative practices and seek advice from other facilitators and the external consultant. All referrals would include a follow-up contact whereby participants would be invited to give feedback on the process.

At the time of the study and across the three group supervision sessions, a range of referrals were discussed. The broad themes of these were instances of verbal and physical harm that had occurred between patients, incidents where patients had threatened harm towards or physically assaulted staff and referrals aimed at repairing harm caused by patients to external victims, which included family members and staff at other settings (i.e. prison, forensic mental health hospital).

2.6 Analysis

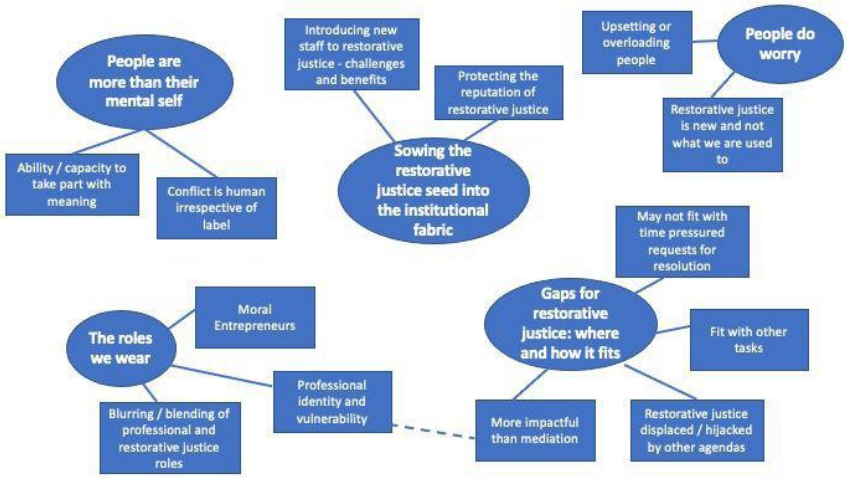
Reflexive thematic analysis (TA) steps were applied to the transcribed supervision sessions to develop themes (Braun & Clarke, 2006). This was initially done independently and then jointly by the study authors to discuss overlap and contrasts in codes and themes. The steps consisted of data familiarisation, generating initial codes, searching for themes, reviewing themes and providing definitions and names to themes. In line with the constructivist approach taken by the study, the interpretation of participant experiences was inductive, where analysis was based on the data, rather than a predetermined theoretical framework. Latent levels of analysis of data, where applied, are presented alongside themes.

Reflections are provided in the discussion to consider influences from the researchers, participants and social context on the conduct of the research and presented findings (Nightingale & Cromby, 1999; Willig, 2001). Five themes were developed from the analysis and are presented in detail in what follows.

3 Findings

An overview of the five themes developed from the three restorative justice group supervision sessions is provided in Figure 1. A description and analysis of the themes is provided thereafter.

Figure 1 Themes from the restorative justice group supervision



3.1 Theme 1: people are more than their mental self

Several discussions took place about where and how experiences of mental health might impact on either the principles or the active ingredients of restorative justice. Examples of this included the ability to connect with the emotional experiences of others and motives for and intentions of taking part.

> X is incredibly suggestable … he wrote a letter that was slightly disconnected from emotion and then I was conscious about how a victim would receive. [Andy]

> Are they able to really use the process in the way that it is intended rather than it being just paying lip service to something? [Riley]

While these issues were considered, repairing harm always came back to the person(s) at the centre of these experiences, and mental health was not considered a diagnosis of exclusion for restorative justice.

> It's a sort of recognition that people are more than their mental self. [Blair]
>
> Conflict is human, we all get into conflict with each other, it doesn't matter what label you wear … it's about how it's resolved isn't it, but we have to be mindful of those things. [Jo]

3.2 Theme 2: the roles we wear

The restorative justice practitioner role was one that happened alongside other roles. A practical implication of this was that it was difficult to find time to 'do' restorative justice:

> There's something about making sure we carve out time that is specifically for this, I don't have a slot in my diary that says this is your restorative justice hour. [Quinn]
>
> I'm sitting here wondering why we're so sparse in here as well. You know it's a reflection on
>
> … That we're struggling to get out and do, to go to CTMs [Clinical Team Meetings], team meetings and stuff like that. I'm X ward champion, and I haven't got a chance to go. [Jesse]

In addition to the time implication from adding a restorative justice practitioner role, there was also discussion around the mixing or blurring of roles and how this might impact on the restorative justice principle of neutrality. This applied not just to restorative justice practitioners but also to supporters and participants:

> I was just wondering whether that would possibly work in this environment because if we're going to be doing restorative justice between patient and patient; they [patients advocates] become a bit compromised. It's probably understandable for them to come and be an advocate when restorative justice is between staff and a patient. But patient to patient … patients are more likely to interpret it as if they're actually one sided. They will not see the neutrality. [Jordan]
>
> I mean in a way you could argue that to hold somebody in [restraint] holds and then 4 weeks later being talked to about restorative justice is actually sending a very powerful message. [Blair]
>
> I've recently taken on a family therapy referral which has a very clear, I've had a clear discussion with the team psychologist saying the reason I want you to do this is because you're a restorative justice practitioner as well. [Quinn]

Finally, there was the potential for a shift in role in the process of taking part in restorative justice. Specifically, this was with reference to staff who may feel a professional identity as being one that does not discuss vulnerabilities, and this could feel at odds with sharing feelings about being harmed.

> Walking in here you have to maintain the brick wall … we're not very good at showing our feelings. [Alex]

3.3 Theme 3: gaps for restorative justice: where and how it fits

How and where restorative justice might be placed within the organisation was a common theme, with several facets to it. Restorative justice was discussed as an extra layer to the therapeutic task, but a complication was disentangling what was restorative and what was therapeutic.

> I think restorative justice has got to be the icing on the cake or it's got to be the extra layer because whatever's happening you still need to do the risk reduction work, you still need to do the mental health work, we still need to have plans for the future…. I think we have probably quite a lot of overlap. [Quinn]

Aligned with the idea of where it was placed, there was also a sub-theme of displacement, where restorative justice could be thought to have been influenced by other agendas:

> Initially it was about the team trying to get him to go to the hospital that Dr C was in so the pressure on both of them, and when that was removed and changed 'so you won't be going back there, you'll be going somewhere else', he still went ahead with it which showed that it wasn't just about going to the hospital, he's gone somewhere else but now the letter means something else. [Reese]

> Is the service accessible for staff, or is it more that it comes through their manager because, it's someone above them, saying you've got to sort this out. [Robin]

The juxtaposition between mediation, a long-standing practice in the service, and restorative justice was often visited in conversations. There was a view that restorative justice may be more impactful in that it was structured and dealt more directly with the consequences of harm. Within this there was reference to what it may be like to 'give yourself' to the restorative justice process, which alluded to stepping out of a professional identity and into one of being someone who was and may still feel harmed and vulnerable. This latter point overlapped with the theme of role change.

> Staff felt mediation was very ad hoc and varied, whereas restorative justice offered a lot more structure and consistency across practices … more of a longer-term fix to conflict … someone said that the difference between restorative justice and mediation was the difference between a plaster and suture, so a plaster comes off but a suture actually fixes itself. [Andy]

> I think with mediation there's not enough of giving yourself is there, people are holding back but with restorative justice because there's lots of homework.… You're encouraged not to hide. [Alex]

However, restorative justice was also thought to be a process that took time, and this might not always fit with the organisational pressures to try and resolve conflict:

> Perhaps when there are issues on a ward because of an assault or an attempted assault and then people are being kept apart because of that, actually restorative justice is probably not the thing because it doesn't fit in with the timescales required by the system. [Riley]

> But I think it did result in a bit of frustration for the team. It went on for a while and they were waiting for something. [Quinn]

3.4 Theme 4: sowing the restorative justice seed into the institutional fabric

References were made to the new status of restorative justice being like a seed. Around those references there were discussions about how to embed this new seed, in terms of helping it to take a foothold in the organisation. This was not so much about the gaps where restorative justice might fit in as, more fundamentally, about ensuring people knew what restorative justice was and that it was an option. This included its 'promotion' to ensure all staff had an opportunity to learn that restorative justice took place and that the earlier in staff's journey in the service, the better:

> First and foremost I think any new starters should be exposed to restorative justice, as opposed to going off to their wards and disappearing … we mustn't drop the ball on staff, because staff are the front line troops, for want of a better word … if they were ambassadors for restorative justice … [Alex]

Finding a space for this promotion among other service priorities was challenging but achievable:

> It's pretty much impossible to get anything into the [staff] induction. We've tried to… [Jaime] … 'we often have the stalls set up then we give out leaflets and that … maybe they'll, you know, if you just … sow the seeds with people'. [Blair]

> I guess that the worry is, is getting people off the wards to go and do the training. Because there's lots of interest, people are really curious about it and want to know more … [now] It's not just me bringing it up as an idea, other people's experience of going to training are now throwing it in, whereas … before it was just me. [Harper]

It seemed to be that establishing restorative justice would be something that took time:

> I seem to find myself on these little situations where I have access to people. I've started learning to just plant some seeds and I'm doing quite a lot of work with X at the moment in central building, so I might just drop that seed in as well. [Frankie]

References were also made to the need to 'protect' the reputation of restorative justice, to ensure it was not perceived as simply another initiative within the service or, more concerningly, that it could be contradictory to the therapeutic task.

> He's put the seed in his mouth and spat it at somebody and now we're having to deal with the fact that somebody's been spat on with a restorative justice seed and they're thinking this restorative justice seed might be contaminated in some way when in actual fact it was protective … because the red herring is 'oh my gosh look at this terrible seed' when in actual fact it was that someone's been spat on with the seed. [Reese]

The potential value in establishing policy and procedures to support the restorative justice seed were discussed. This would ensure that best practices could be followed for case referrals and that relevant stakeholders involved in the wider clinical task of the service could understand the restorative justice process, to best inform their input into restorative justice referrals.

> The system is full of power and right at the heart of it, I suppose the clinical team needs to drive … access for vulnerable individuals to things and I think we always have to work very closely with that system … So how do we operate with absolute sensitivity in the organisation, how do we protect ourselves from I suppose the reputational damage of 'oh somebody was offered restorative justice and that wasn't helpful'… So I suppose to bullet proof just a little bit, we set out our processes really clearly. [Jo]

> We follow procedures so we don't give anybody any chance, no ammo, that's how it should be. [Alex]

3.5 Theme 5: people do worry

The idea of bringing together people who have been affected by harm and those that have caused it seemed to feel risky. How it might impact on a person's well-being was considered:

> It's not happening due to, for reasons that patient is trying to leave and doesn't want to get upset and the team agree he shouldn't get upset before he leaves. [Quinn]

> We thought that at the minute, he's got quite a heavy timetable, he got some good news about the RSU [Regional Secure Unit] so we thought we'll just keep it on, pause it for now and then perhaps next time … He's got a lot on his plate at the minute, he's kind of engaged with all sorts of different groups and different therapies … so we don't want to overload. [Robin]

A challenge to this thinking was where the concern was coming from, and how it might be overcome:

> But when restorative justice isn't considered because the fear of even mentioning the harm. I guess, in the conversation's I've had that's felt very much more a professional fear as opposed to any fear coming from patients who might be interested … it's not even the two parties that don't want to do it, it's more the fear around the clinical team not wanting to rock the boat. [Teri]

> I think the clinical team does need to take that positive risk and I suppose the best way is through sharing anecdotes of where positive risk has been taken because people do worry, it's an unusual thing to do isn't it. [Quinn]

> The knowledge of both sides normally and now we're in a different position, and we don't know, and it leaves us feeling unsettled and it leaves us exploring lots of options. [Quinn]

4 Discussion

Restorative justice is a relatively new concept for forensic mental health services. With its new status there are opportunities to explore where and how the practices of repairing harm can happen within these services. This is a necessary area of inquiry, as the process and experiences of introducing restorative justice into criminal justice settings can be shaped by the contexts in which it takes place, and this may have implications for its purpose and objectives. Experiences of implementation have also often been overlooked in the restorative justice literature. The current study aimed to explore the provision of restorative justice in a forensic mental health setting by studying the content of restorative justice practitioners' discussions in group case supervision.

4.1 The use of restorative justice with people with mental health needs – people are more than their mental self

An analysis of what appears to underpin this theme is that assumptions will be made about the intentions and abilities of others to participate, and these assumptions might be influenced by the responsibility of facilitating restorative justice and not causing further harm. Riley's statement alludes to worries about people's motivations for taking part, which is a concern that is considered in other fields of restorative justice practice (e.g. Stubbs, 2004). Navigating these assumptions relates to some of the ethical principles that have been discussed with

reference to restorative justice in forensic mental health and other criminal justice settings (Drennan & Swanepoel, 2022; Kirkwood, 2021). There may be a dilemma between balancing the duty of care to the person harmed and the knowledge-related assumptions about whether the person who caused harm is capable (and has the intention) of taking responsibility and making amends.

While these potential challenges were highlighted, the focus on repairing harm was not overruled by them, and there was no indication that mental illness in the broad meant a reason for exclusion from restorative justice. These perspectives lend some support to the theoretical and legislative arguments that restorative justice has a place in such settings and are also perspectives echoed by forensic mental health professionals with practice-based experiences of restorative justice with forensic patients (e.g. Cook et al., 2015; van Denderen et al., 2020). Given the infancy of research in this area, there are only case examples of how far restorative practices have gone when mental health# features in the harm caused (e.g. Cook, 2019; Liebmann, 2007; Robinson, Vivian-Byrne, Driscoll & Cordess, 1991). Further establishing how mental health experiences might impact on restorative practices would be beneficial to inform whether any adaptations are needed that could support access to and benefit from them. This may also help inform decision-making around the suitability of referrals, given the theme about worry from clinical decision makers and practitioners, who have a duty of care to cause no harm. The importance of communicating what the restorative justice process involves, including procedures for identifying and mitigating any risks, and sharing case examples of what works (and does not) would equally be useful for decisions about suitability (Cook et al., 2015).

4.2 Staff who facilitate or participate in restorative justice – the roles we wear

The practical and resource implications for holding a restorative justice facilitator role alongside other roles represented the pressures of being moral entrepreneurs. This has been experienced in other criminal justice contexts where restorative justice was provided (Skogan, 2008). The principle of neutrality was discussed with reference to roles. There was a perception that forensic patients may be unable to 'see' neutrality if staff have dual roles. A more fundamental assumption underpinning this idea was that neutrality could be achieved at all. Another view was the perceived benefits of 'non-neutrality', whereby a professional role complements that of a restorative justice facilitator and having dual roles might harness or optimise outcomes. This complementarity has been voiced in another forensic mental health setting (Cook et al., 2015). It was interesting to note that there were fewer discussions about whether dual roles were counterproductive to outcomes. In other criminal justice settings, dual roles have been said to give too much power to one agency (Ashworth, 2001). Some have argued that power dynamics are inevitable in the restorative justice process (Lyubansky & Shpungin, 2015; Willis, 2020). Forensic mental health staff will be 'agents' of the systems that deliver restorative work and are therefore embedded (entangled) with the structural power of those systems. However, practitioners in these settings do have existing experience of oscillating between different roles and responsibilities (e.g. patient

care and public safety), so it may be the case of navigating how to include restorative justice within or alongside these (Ward, 2017).

A final role shift that was discussed was specifically in the context of staff as participants in restorative justice. References to staff 'not hiding' and being a 'brick wall' seemed to suggest that talking about the impact of being harmed could feel exposing and that dropping one's guard might lead to feeling vulnerable. In the same way that people detained in forensic settings who participate in restorative justice may need to build a moral identity at odds with the institutional culture (Guidoni, 2003), staff who participate may be asked to talk about the impact of harm on them and how they have been affected, which may feel at odds with professional training about self-disclosures and boundaries that aims to promote relational security (Chester, Alexander & Morgan, 2017). A further discussion point here is around professional identity. Discourses about staff identities, particularly forensic psychiatric nurses who are arguably at the greatest risk of harm given the nature of their role, may present challenges if there is a culture of not talking about being affected (Mason, Lovell & Coyle, 2008). This may be compounded by perceptions that risk is simply part of the job and what it might therefore mean if a staff member experiences harm as something difficult. Evidence that there is a reluctance in the reporting of being harmed at work and a low uptake of support following such events may be indicative of these issues (Seto, Rodrigues, Ham, Kirsh & Hilton, 2020; van Leeuwen & Harte, 2011). This assumption is further supported by staff voices that highlight professional identity and stigma as factors that influence how being harmed is dealt with (Rodrigues, Ham, Kirsh, Seto & Hilton, 2021).

4.3 Embedding restorative justice into forensic mental health settings – gaps for restorative justice: where and how it fits

This theme seemed to represent how facilitators thought that restorative justice interacted with other values, needs and practices of the organisation. There was, at times, a feeling of pressure to ensure timely delivery of restorative justice. Several assumptions seemed to surround the voluntariness of restorative justice and the importance of context. There was a view that restorative justice might be 'done to' rather than 'done with', depending on what the purpose was and who requested it. A concern was that this could have implications for the potential to benefit. There was also reference to restorative justice being in addition to (but not in place of) risk reduction work, with a suggestion of overlap. This positioning of restorative justice might be understood by some of the debates on how different rehabilitation ideas have been introduced into criminal justice settings over time (Robertson, Barnao & Ward, 2011). Part of these debates have focused questions on the degree to which established and contemporary rehabilitation ideas are juxtaposed-inter-dependent with one another, which resembled facilitators' experiences here. The conceptual overlap between restorative justice and offender rehabilitation ideas has been analysed (see Ward, Fox & Garber, 2014). A conclusion from this work, which arguably extends to restorative justice in the forensic mental health field, is that the spaces between these ideas are yet to be demarcated and understood in

terms of the possibilities for complementary and unique principles, practices and objectives.

One existing practice at the study setting that was felt restorative justice shared objectives with but could provide more than was mediation. Mediation was a long-standing approach that brought together people affected by harm, with the aim of being able to move forward without further conflict or risk. However, it was generally unstructured, and therefore varied in its delivery, and did not tend to focus on the individual impacts of harm but more the agreement to be safe around one another. The potential for restorative justice was that it could, by comparison, be more meaningful and impactful, given its emphasis on emotional connection, responsibility and reparation. The importance of being clear about the distinctions between the purpose, process and possible outcomes of these different approaches has been advised (see Brookes & McDonough, 2006). This would support decision-making about whether to take part and how to inform expectations. It could also reduce ambiguity about what restorative justice is, which can have implications for its establishment. Reflections from facilitators were that time would also be needed for restorative justice referrals to achieve benefits. This meant restorative justice may not always fit with pressures or needs of the organisation, so communicating the process to both inform expectations and consider whether more expedient options might be better suited are further implications to consider. Related to organisational drivers were discussions specific to the restorative justice principles of restoration and voluntarism. Potential challenges to maintaining these principles within a 'privilege system'[5] were highlighted, whereby stipulations or conditions may become attached to restorative justice work that could then influence the decision to opt in. One example given in the current study was the potential pressure to do restorative justice to be able to be discharged. It is important here not to conclude that if the motivation to participate is other or more than to repair or restore, then these outcomes will not be reached (Presser & Lowenkamp, 1999). Nonetheless, discussing the degree of voluntarism that participants perceive there to be would usefully inform understanding about the balance of rights (Ward & Langlands, 2008).

4.4 The process of establishing restorative justice: sowing the restorative justice seed into the institutional fabric

The theme of sowing restorative justice into the institutional fabric overlapped with experiences of introducing restorative justice into other criminal justice settings (e.g. Marder, 2020). References to ward staff being potential 'ambassadors' for restorative justice and 'frontline troops' by one facilitator was understood as the significant role of ward staff in embedding restorative justice. As this group represents the largest profession in the service, introducing them to opportunities and scope for restorative justice could enable a shift from a small group of moral entrepreneurs promoting these to a larger group of restorative justice 'ambassadors'. There was a view that once new staff completed their induction and were on the

5 Privilege system: a system that provides rewards and special privileges for good behaviour (Goffman, 1968).

wards it would be more difficult for staff to step away from this duty to learn about restorative justice.

It was felt that embedding restorative justice would need time, and a challenge to this was how it fitted in with all other trainings and initiatives within the service. A further reference to supporting its new status within the system was how to 'protect it'. The language used to discuss a restorative justice referral that was thought to have caused distress but that was felt by facilitators to be a 'red-herring' points to the need for a dialogue between the wider organisation and a group within it delivering restorative justice. This emphasises the importance for communication, particularly where two parts of a system ascribe different meanings to the same event (Pearce, 2005). This inference is shaped by learning from an innovation introduced into a similar secure hospital setting, where the positioning between the wider organisation and the innovators was interpreted at odds at times with one another in terms of their values (Taylor, 2017). The implications of this miscommunication may shape perceptions about the reputation of newly introduced practices. There is said to be a tendency for such new ideas, including restorative justice, to initially be viewed by those outside with suspicion and resistance (Bastiansen & Vercruysse, 2002). Of course, there may indeed be actual risks from talking about harm and if restorative justice is then experienced as counterproductive to institutional efforts (security and therapeutic) to reduce risk, this could cause concern. This highlighted the need for having safe practice processes in place but perhaps more importantly the need to communicate closely with other clinical decision makers to share these and engage in discussions about how to deliver restorative justice safely and effectively.

4.5 Worries about bringing people together to talk about harm: people do worry

Discussions about why some restorative justice referrals for patients were not pursued highlighted anxieties that the work could be unsettling or was not at the right time. Readiness is an important consideration in rehabilitation work and would reasonably apply to restorative justice. Within the restorative justice process, determining suitability is a part of the preparation work. But it was interesting to note that decisions about readiness might be made before this assessment takes place. The assumptions seemed less about readiness, and the 'hold' placed on referrals was more due to what was prioritised and the potential for anything extra to jeopardise this. The primary task of the setting is to help patients reduce their risk, restore their mental health and progress to a lesser secure environment. So, understandably, those involved in this task have an investment and may be mindful of work that directly approaches past harms, which may be difficult. However, a challenge to take to this position is to ask whether maintaining the status quo is justifiable or could potentially reduce the opportunity for psychological growth (Felton, Wright & Stacey, 2017). This theme emphasises that restorative justice is not without potential risks, which may not be able to be fully extinguished. But neither are other interventions that are provided in these settings. The same ethical considerations should apply to referrals for restorative justice as for the use of medication or psychosocial therapies.

There are several strengths and limitations of the study that warrant discussion. The constructivist approach taken to investigating experiences of delivering restorative justice referrals in a forensic inpatient hospital meant that the discussions analysed were not guided by research questions or input or interruptions from the researchers. Therefore, the findings are closely aligned to the experiences of those implementing restorative justice (Denzin, 1971). To promote the credibility of the themes generated, the second study author was independent of the restorative justice work at the study site but also applied TA to the supervision sessions, and these were discussed alongside the coding and theming done by the first author, who was part of the restorative justice supervision sessions. This aimed to support the trustworthiness of the themes, in that alternative explanations for the data were discussed in a series of joint meetings where codes and themes were reviewed (Marshall, 1985). As the discussions took place in group supervision and with a myriad of professional groups, a wide range of differing knowledge and experiences were included, and the discursive nature of the supervision allowed for salient issues to be uncovered (Morgan, 1988). This brings a degree of transferability in that the themes could be applicable to other forensic inpatient settings (Lincoln & Guba, 1985). In terms of limitations, the presence of one of the study authors in the supervision sessions challenges the sense of neutrality or objectiveness. While these are not aligned with epistemological assumptions of a constructivist approach to research, the meta-positions of the researcher will still influence the choice of research question, method, analysis and interpretation of the data (Malterud, 2001). As a restorative justice facilitator, the first author recognises an invested interest in its 'success'. A post-analysis reflection was how more emphasis, or even responsibility, was placed on how the organisation responded to restorative justice, with less critical analysis of whether restorative justice might not work within this setting. It has been said to be easy to blame the wider system for not welcoming a new set of ideas but arguably more useful to try and understand the experiences of facilitators alongside the position of the organisation (Taylor, 2017). A further limitation from the chosen method was the extent to which the meaning behind participant contributions was embedded in restorative justice experiences or other systemic or personal experiences that shaped these views (Pierce, 2018). Contributions may have also been influenced by participants being aware that the sessions were audio recorded. Lastly, concerning the credibility of interpretations made from individual experiences, no process of checking finalised themes with participants (i.e. membership validation) was conducted (Lincoln & Guba, 1985).

On the basis of the findings discussed in this article, the following reflections on implementation implications could be summarised:

– Staff trained as restorative justice facilitators would benefit from dedicated and protected time to undertake referrals.
– Investment in restorative justice training and infrastructure (e.g. dedicated practitioners) would support a move from a small group of trained individuals to the wider community and the organisation.

– The option for drafting in external restorative justice practitioners, who are not agents of the systems, may be helpful, particularly if there are difficulties with neutrality.
– Establishing procedures for referral allocation and providing supervision and reflective spaces are beneficial for monitoring case work and considering the extent to which the principles of restorative justice are being met.

The following research recommendations are informed by the study findings and knowledge gaps in the literature on restorative justice in relation to mental health and mental health settings:
– Restorative justice case studies would be useful in learning how mental health experience impacts on process and outcomes.
– Research that investigates whether a plurality of roles has implications for the delivery of restorative justice, and how participants experience this, is recommended.
– Investigating motivation and engagement to participate in restorative justice in forensic mental health settings is recommended, to consider factors that might inform practitioners about readiness in addition to considering barriers to accessing restorative justice.

References

Ashworth, A. (2001). Is restorative justice the way forward for criminal justice?. *Current Legal Problems*, 54(1), 347. doi: 10.1093/clp/54.1.347.

Barabás, T., Fellegi, B. & Windt, S. (2012). *Responsibility-taking, relationship building and restoration in prisons*. Budapest: foresee Research Group. Retrieved from http://mereps.foresee.hu/ (last accessed 21 March 2018).

Bastiansen, R. & Vercruysse, J. (2002). Review of restorative justice in Belgium prisons: commentary on responding to the crisis. *Prison Service Journal*, 140, 18-20.

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21(6), 499-508. doi: 10.1111/jpm.12129.

Bradshaw, W. & Roseborough, D. (2005). Restorative justice dialogue: the impact of mediation and conferencing on juvenile recidivism. *Federal Probation*, 69(2), 15-21.

Braithwaite, J. (2002). *Restorative Justice and Responsive Regulation*. Oxford: Oxford University Press.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa.

Brookes, D. & McDonough, I. (2006). The differences between mediation and restorative justice/practice. Retrieved from https://www.researchgate.net/profile/Derek-Brookes/publication/335704100 (last accessed 25 January 2022).

Chester, V., Alexander, R.T. & Morgan, W. (2017). Measuring relational security in forensic mental health services. *BJPsych Bulletin*, 41(6), 358-363. doi: 10.1192/pb.bp.116.055509.

Clairmont, D. (2011). Penetrating the walls: implementing a system-wide restorative justice approach in the justice system. In E. Elliot & R. Gordon (eds.), *New directions in restorative justice: issues, practice, evaluation* (pp. 245-265). London: Routledge.

Clamp, K. & Paterson, C. (2013). An exploration of the role of leadership in restorative policing in England and Wales. In A.H. Normore & N.D. Erbe (eds.), *Collective efficacy: interdisciplinary perspectives on international leadership* (pp. 293-307). doi: 10.1108/S1479-3660(2013)0000020016.

Cook, A. (2019). Restorative practice in a forensic mental health service: three case studies. *The 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 & Psychology*, 26(4), 510-531. doi: 10.1080/14789949.2015.1034753.

Crawford, A. (2006). Institutionalizing restorative youth justice in a cold, punitive climate. In I. Aertsen, T. Daems & L. Robert (eds.), *Institutionalizing restorative justice* (pp. 120-150). Cullompton: Willan Publishing.

Daly, K. (2002). Restorative justice: the real story. *Punishment & Society*, 4(1), 55-79. doi: 10.1177/14624740222228464.

Daly, K. (2016). What is restorative justice? Fresh answers to a vexed question. *Victims & Offenders*, 11(1), 9-29. doi: 10.1080/15564886.2015.1107797.

Daly, K. & Immarigeon, R. (1998). The past, present, and future of restorative justice: some critical reflections. *Contemporary Justice Review*, 1(1), 21-45.

Denzin, N. (1971) The logic of naturalistic inquiry. *Social Forces*, 50(2), 166-182. doi: 10.2307/2576935.

Department of Health (2018). *Governance arrangements for research ethics committees: a harmonised edition*. Leeds: Department of Health.

Drennan, G. (2014). Restorative practice in forensic mental health. *Resolution*, 51(Spring), 10-11.

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: managing the power within* (pp. 105-120). Farnham: Ashgate.

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

Drennan, G. & Swanepoel, F. (2022). Restorative justice practice in forensic mental health settings: bridging the gap. *The International Journal of Restorative Justice*, 5(2), 168-191. doi:

Edwards, P. (2015). Where, how, who? Some questions for restorative justice. *Safer Communities*, 14(3), 138-146. doi: 10.1108/SC-05-2015-0014.

Felton, A., Wright, N. & Stacey, G. (2017). Therapeutic risk-taking: a justifiable choice. *BJPsych Advances*, 23(2), 81-88. doi: 10.1192/apt.bp.115.015701.

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. *Developments in Mental Health Law*, 22, 1.

Gavrielides, T. (2014). Reconciling the notions of restorative justice and imprisonment. *The Prison Journal*, 94(4), 479-505. doi: 10.1177/0032885514548010.

Goffman, E. (1968). *Asylums: essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.

Guidoni, O.V. (2003). The ambivalences of restorative justice: some reflections on an Italian prison project. *Contemporary Justice Review*, 6(1), 55-68. doi: 10.1080/1028258032000055658.

Gunn, J. (2000). Future directions for treatment in forensic psychiatry. *The British Journal of Psychiatry*, 176(4), 332-338. doi: 10.1192/bjp.176.4.332.

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 criminal offenders with a mental disorder. *Buffalo Law Review*, 60, 147-223.

Haigh, R., Harrison, T., Johnson, R., Paget, S. & Williams, S. (2012). Psychologically informed environments and the "Enabling Environments" initiative. *Housing, Care and Support*, 15(1), 34-42. doi: 10.1108/14608791211238412.

Hardy, S.A. & Carlo, G. (2005). Identity as a source of moral motivation. *Human Development*, 48(4), 232-256. doi: 10.1159/000086859.

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. doi:

Harwood, C. (2020). Restorative justice in forensic mental health settings. Retrieved from https://cij.org.au/cms/wp-content/uploads/2020/11/restorative-justice-in-forensic-mental-health-settings-eliza-hew.pdf (last accessed 2 March 2022).

Karstedt, S. & Rossner, M. (2019). Understanding emotions in restorative justice: transcending myths and scepticism. *The International Journal of Restorative Justice*, 2(3), 363-367. doi: 10.5553/IJRJ.000007.

Kaur, M., De Boer, R.J., Oates, A., Rafferty, J. & Dekker, S. (2019). Restorative just culture: a study of the practical and economic effects of implementing restorative justice in an NHS trust. In MATEC Web of Conferences (Vol. 273, p. 01007). EDP Sciences. Retrieved from www.matec-conferences.org/articles/matecconf/abs/2019/22/matecconf_icsc_eswc2018_01007/matecconf_icsc_eswc2018_01007.html (last accessed 11 August 2020).

Kirkwood, S. (2021). A practice framework for restorative justice. *Aggression and Violent Behavior*, 101688. doi: 10.1016/j.avb.2021.101688.

Latimer, J., Dowden, C. & Muise D. (2005). The effectiveness of restorative justice practices: a meta-analysis. *The Prison Journal*, 85(2), 127-144. doi: 10.1177/0032885505276969.

Leung, M. (1999). The origins of restorative justice. Retrieved from https://www.cfcj-fcjc.org/sites/default/files/docs/hosted/17445-restorative_justice.pdf (last accessed 29 July 2023).

Liebmann, M. (2007). *Restorative justice: how it works*. London: Jessica Kingsley Publishers.

Lincoln, Y.S. (2007). Naturalistic inquiry. In G. Ritzer (ed.), *The Blackwell encyclopedia of sociology*. doi: 10.1002/9781405165518.wbeosn006.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.

Lyubansky, M. & Shpungin, E. (2015). *Challenging power dynamics in restorative justice*. In T. Gavrielides (ed.), *The psychology of restorative justice: managing the power within* (pp. 183-203). Farnham: Ashgate.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483-488. doi: 10.1016/S0140-6736(01)05627-6.

Marder, I.D. (2016). Funding restorative justice in England and Wales. *The Justice Gap*. Retrieved from www.thejusticegap.com/funding-restorative-justice-england-wales/ (last accessed 16 February 2020).

Marder, I.D. (2020). Institutionalising restorative justice in the police: key findings from a study of two English police forces. *Contemporary Justice Review*, 23(4), 500-526. doi: 10.1080/10282580.2020.1755847.

Markham, S. (2021). The totalising nature of secure and forensic mental health services in England and Wales. *Frontiers in psychiatry*, 12, 789089. doi: 10.3389/fpsyt.2021.789089.

Marshall, C. (1985). Appropriate criteria of the trustworthiness and goodness for qualitative research on educational organizations. *Quality and Quantity*, 79, 353-373.
Marshall, T.F. (1999). *Restorative justice: an overview*. London: Home Office.
Martin, P, S., Campbell, E. & Bickle, K. (2023). Restorative Justice Practices in Forensic Mental Health Settings - A Scoping Review. *International Journal of Forensic Mental Health*, 22(2), 147–158. https://doi.org/10.1080/14999013.2022.2105992
Mason, T., Lovell, A. & Coyle, D. (2008). Forensic psychiatric nursing: skills and competencies: I role dimensions. *Journal of psychiatric and mental health nursing*, 15(2), 118-130. doi: 10.1111/j.1365-2850.2007.01191.x.
McCold, P. (1999). *Restorative justice practice: the state of the field 1999*. Retrieved from https://www.iirp.edu/news/restorative-justice-practice-the-state-of-the-field-1999 (last accessed 29 July 2023).
Mental Health Act 1983. London: HMSO. Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/contents (last accessed 29 July 2023).
Morgan, D.L. (1988). *Focus groups as qualitative research*. London: Sage.
Neilson, G. (2006). The four factors of organizational DNA. *Harvard Business*, 33, 1-10.
NHS England (2021). *Service specification, adult high secure services*. Retrieved from www.england.nhs.uk/publication/service-specification-high-secure-mental-health-services-adult/ (last accessed 3 May 2021).
Nightingale, D. & Cromby, J. (1999). *Social constructionist psychology: a critical analysis of theory and practice*. Buckingham: Open University Press.
Oudshoorn, J. (2015). *Trauma-informed rehabilitation and restorative justice*. In T. Gavrielides (ed.), *The psychology of restorative justice: managing the power within* (pp. 159-182). London: Routledge.
Pearce, W.B. (2005). The coordinated management of meaning (CMM). In W.B. Gudykunst (ed.) *Theorizing about intercultural communication* (pp. 35-54). Thousand Oaks: Sage.
Pierce, T. (2018). *Naturalistic observation*. Department of Psychology. Radford University. Retrieved from www.radford.edu/~tpierce/201%20files/201%20handouts/Naturalistic%20Observationl%20ecture%20notes.pdf (last accessed 16 June 2022).
Power, M. (2017). *International innovations in restorative justice in mental health – next steps for Australia*. Retrieved from https://restorativejustice.org.uk/sites/default/files/resources/files/Michael-Power-Churchill-Fellowship-Restorative-Approaches-in-Mental-Health-V2.pdf (last accessed 2 March 2022).
Presser, L. & Lowenkamp, C.T. (1999). Restorative justice and offender screening. *Journal of Criminal Justice*, 27(4), 333-343.
Quinn, J., & Simpson, A. I. F. (2013). How Can Forensic Systems Improve Justice for Victims of Offenders Found Not Criminally Responsible? *The Journal of the American Academy of Psychiatry and the Law*, 41(4), 568–574. Retrieved from https://jaapl.org/content/41/4/568.long (last accessed 29 July 2023).
Restorative Justice Council (2016). *Practitioner Handbook*. Norwich: Restorative Justice Council. Retrieved from https://restorativejustice.org.uk/sites/default/files/resources/files/Practitioners%20Handbook_0.pdf (last accessed 11 February 2023).
Roberts, G., Dorkins, E., Wooldridge, J. & Hewis, E. (2008). Detained–what's my choice? Part 1: Discussion. *Advances in Psychiatric Treatment*, 14(3), 172-180. doi: 10.1192/apt.bp.107.003533.
Robertson, P., Barnao, M. & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472-484. doi: 10.1016/j.avb.2011.03.003.

Robinson, S., Vivian-Byrne, S., Driscoll, R. & Cordess, C. (1991). Family work with victims and offenders in a secure unit. *Journal of Family Therapy*, 13(1), 105-116. doi: 10.1046/j..1991.00415.x.

Rodrigues, N.C., Ham, E., Kirsh, B., Seto, M.C. & Hilton, N.Z. (2021). Mental health workers' experiences of support and help-seeking following workplace violence: a qualitative study. *Nursing & Health Sciences*, 23(2), 381-388. doi: 10.1111/nhs.12816.

Rossner, M. (2011). Emotions and interaction ritual: a micro analysis of restorative justice. *The British Journal of Criminology*, 51(1), 95-119.

Seto, M.C., Rodrigues, N.C., Ham, E., Kirsh, B. & Hilton, N.Z. (2020). Post-traumatic stress disorder, depression, anxiety symptoms and help seeking in psychiatric staff: Trouble de stress post-traumatique, dépression, symptômes d'anxiété et recherche d'aide chez le personnel psychiatrique. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 65(8), 577-583. doi: 10.1177/0706743720916356.

Sherman, L.W., Strang, H., Angel, C., Woods, D., Barnes, G.C., Bennett, S. & Inkpen, N. (2005). Effects of face-to-face restorative justice on victims of crime in four randomized, controlled trials. *Journal of Experimental Criminology*, 1(3), 367-395. doi: 10.1007/s11292-005-8126-y.

Skogan, W. (2008). Why reforms fail. *Policing and Society*, 18(1), 23-34. doi: 10.1080/10439460701718534.

Strang, H. & Sherman, L.W. (2003). Repairing the harm: victims and restorative justice. *Utah Law Review*, 15, 15-42.

Stubbs, J. (2004). Restorative justice, domestic violence and family violence. Australian Domestic & Family Violence Clearinghouse, Issues Paper 9. Retrieved from https://www.indigenousjustice.gov.au/wp-content/uploads/mp/files/resources/files/issues-paper-9.pdf (last accessed 22 March 2023).

Taylor, J. (2017). Democratisation, disability and defence mechanisms: reality confrontation in Rampton. In G. Akerman, A. Needs & C. Bainbridge (eds.) *Transforming Environments and Rehabilitation* (pp. 198-212). London: Routledge.

Taylor, P.J., Dunn, E., Felthous, A.R., Gagné, P., Harding, T., Kaliski, S., Kramp, P., Lindqvist, P., Nedopil, N., Ogloff, J., Skipworth, J., Thomson, L, Yoshikawa, K, Adserballe, H., Berner, W., Dontschev, P., Hucker, S.J., Jablensky, A., Westmore, B. & Wettstein, R.M. (2014). Forensic psychiatry and its interfaces outside the UK and Ireland. In J. Gunn, P. Taylor & I.D. Hutcheon (eds.), *Forensic psychiatry* (pp. 111-147). London: Routledge.

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 Leeuwen, M.E. & Harte, J.M. (2011). Violence against care workers in psychiatry: is prosecution justified? *International Journal of Law and Psychiatry*, 34(5), 317-323. doi: 10.1016/j.ijlp.2011.08.011.

Van Ness, D.W. (2001). Restorative justice around the world. *Paper presented to meeting of UN Expert Group on Restorative Justice*, 29 October – 1 November 2001, Ottawa, Canada.

Van Ness, D.W. (2005) An overview of restorative justice around the world. *Paper presented at Workshop 2: Enhancing criminal justice reform, including restorative justice. United Nations 11th Congress on Crime Prevention and Criminal Justice*, 22 April. Bangkok, Thailand. Retrieved from https://biblioteca.cejamericas.org/bitstream/handle/2015/4767/dan_van_ness_final_paper.pdf?sequence=1&isAllowed=y (last accessed 29 July 2023).

Victims' Commissioner. Entitlements and experiences of victims of mentally disordered offenders. Victims' Commissioner, 2018. Retrieved from https://restorativejustice.org.uk/sites/default/files/resources/files/Victims-of-MDO-report%20June%202018.pdf (last accessed 17 May 2019).

Ward, T. (2017). Restorative justice and the dual role problem confronting practitioners. In E. Zinsstag & M. Keenan (eds.) *Restorative responses to sexual violence: legal, social and therapeutic dimensions* (pp. 92-107). London: Routledge.

Ward, T., Fox, K. J., & Garber, M. (2014). Restorative justice, offender rehabilitation and desistance. *Restorative Justice: An International Journal*, 2(1), 24–42. https://doi.org/10.5235/20504721.2.1.24

Ward, T. & Langlands, R.L. (2008). Restorative justice and the human rights of offenders: convergences and divergences. *Aggression and Violent Behavior*, 13(5), 355-372. doi: 10.1016/j.avb.2008.06.001.

Willig, C. (2001) *Introducing qualitative research in psychology: adventures in theory and method*. Buckingham: Open University Press.

Willis, R. (2020). 'Let's talk about it': why social class matters to restorative justice. *Criminology & Criminal Justice*, 20(2), 187-206. doi: 10.1177/1748895818804307.

Zehr, H. (1995). Justice paradigm shift: values and visions in the reform process. *Mediation Quarterly*, 12(3), 207-216. doi: 10.1002/crq.3900120303.