

Restorative Justice in Forensic Mental Health settings

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1 Background

RMIT University's Centre for Innovative Justice (CIJ) has had preliminary discussions with Forensicare staff (Chief Social Worker Lisa Wright & acting Chief Social Worker Sarah Harvey) to explore opportunities to embed restorative justice practices within Thomas Embling Hospital. Following on from these discussions, Open Circle, the restorative justice service within the CIJ, has engaged a RMIT JD student to create a grounding piece of work on this topic. This report aims to inform a best practice approach when implementing restorative practice in forensic mental health settings. This report identifies the potential benefits of restorative justice practices for staff, patients, family members and the broader community, as well as highlighting key practice considerations for any restorative intervention in this setting. This report also identifies any challenges and conflicts between restorative justice and forensic treatment approaches. All practice considerations have been drawn from domestic and international literature on active programs of RJ in forensic mental health settings.

A note on terminology

Restorative justice (RJ) has its roots in the criminal justice system, where participants are typically called 'victims' and 'offenders'. This report highlights from the outset that language is important; labels can be stigmatising and reductive, particularly given the blurred boundaries of victimisation and offending.¹ Further, RJ has increasing application outside of the criminal justice system, where the terms 'victim' and 'offender' are not only inappropriate, they are inaccurate. Thus, the terminology 'person harmed' and 'person responsible for the harm' is preferred and is used in this report. As an additional layer of the complexity of language, this report is centred on forensic mental health institutions, where the terminology of 'patients', 'staff' and 'victims of index

¹ Kathleen Daly, 'Feminist perspectives in criminology: A review with Gen Y in mind' in E. McLaughlin and T. Newburn (ed), *The SAGE handbook of criminological theory* (Sage Publications, London, 2010) 225.

offence' are used. The term 'index offence' is used to refer to the offence that led to the person becoming a patient of a forensic mental health service. In an aim to remain true to preferred terminology, but also to provide clarity of meaning, this report will use the terms 'patient responsible for the harm', 'staff harmed', 'patient harmed' and 'victim of index offence'.

2 Introduction

2A *What is restorative justice?*

There is no single definition of restorative justice. RJ has been described as a philosophy, a process and an approach to justice, which aims to acknowledge the harm done to all parties affected by a crime. In this process, all parties come together to collectively decide how to address the harm and deal with its implications for the future.² RJ recognises that harms take place within a network of relationships; a crime is not simply a violation of the law, but a 'ruptured relationship between the victim and the offender'.³ Within a RJ framework, a victim may be offered the opportunity to ask questions and describe the impact of the harm on their life. An offender on the other hand, may be offered the opportunity to express remorse. RJ recognises the limitations of traditional, punitive responses to criminal offending, which are characterised by 'just deserts' and retribution. Instead, it offers an alternative (or supplementary) avenue for victims in an attempt to meet their needs. RJ has been linked to Braithwaite (1989) theory of 'reintegrative shaming', which involves the public disavowal of deviant behaviour (not the deviant person),⁴ who is then offered an opportunity to make reparations for their harmful behaviour and be 'reintegrated'. RJ may manifest in a structured intervention between all relevant stakeholders and a facilitator, or may exist in a more informal restorative communication process.

2B *Justice needs*

² Tony Marshall, 'The evolution of restorative justice in Britain' (1996) 4 *European Journal on Criminal Policy and Research* 31, 37.

³ Howard Zehr, *Changing lenses: A new focus for crime and justice* (Herald Press, Scottsdale, PA 1990) 181.

⁴ Michael King, Arie Freiberg, Becky Batagol & Ross Hyams (eds), *Non-Adversarial Justice* (The Federation Press, 2nd ed, 2014) 57.

Restorative justice can also be understood through a framework of ‘justice needs’ (or interests).⁵ RJ is one type of ‘justice mechanism’, capable of meeting the unmet needs of individuals impacted by harm, in a way that is often not possible by the traditional criminal justice process. According to Daly (2014), a victims’ ‘justice needs’ may include participation, voice, validation, relationships, prevention and accountability.⁶ A failure to meet these needs will contribute to a sense of injustice experienced by the person who has been harmed. Similarly, Toews (2006), drawing from her own work as a RJ practitioner in the context of prisons, outlines eight ‘justice needs’ common among persons affected by wrongdoing.⁷ For Toews, these include: relationships, safety, empowerment, information, venting, growing, accountability and meaning.⁸ In Bolitho’s 2015 study on processes and outcomes for victims of serious crime in NSW, Australia, she found that for every victim, there was, at minimum, one clearly identified ‘unmet justice need’, despite a guilty finding at court.⁹ A restorative intervention in a forensic mental health setting has the potential to meet the needs of victims that have not been met by other criminal or therapeutic interventions. To ground the idea of ‘justice needs’ in the current context, I will provide some illustrative examples: a patient’s family member who has been harmed by the patient may value **accountability**, but also the reparation of the **relationship**. A forensic staff member who has been harmed by a patient on the ward may require **voice** and **participation** to explain the impact of the harm. A victim of an index offence may ask for **information** from the patient responsible for the harm and an assurance of **prevention** from it happening to another, as well as an opportunity to make **meaning** of, and **grow** from, the experience. Where ‘justice needs’ are not met by the criminal justice system, persons harmed may feel a sense of injustice and seek a justice process that can deliver on their needs. Restorative justice provides a methodology for understanding such needs and restorative processes provide a mechanism for meeting them.

2C What is a forensic mental health setting?

⁵ Kathleen Daly, ‘Reconceptualising sexual victimisation and justice’ in Inge Vanfraechem et al (ed), *Justice for Victims: Perspectives of Rights, Transition and Reconciliation* (Taylor & Francis Group, 2014) 378. Note, Daly prefers the term victims’ justice interests, than needs, to connote a victim’s standing as a citizen in a justice activity: 388

⁶ Ibid 388.

⁷ Barb Toews, *Little Book of Restorative Justice for People in Prison: Rebuilding the Web of Relationships* (Good Books, 2006).

⁸ Ibid 25.

⁹ Jane Bolitho, ‘Putting justice needs first: a case study of best practice in restorative justice’ (2015) 3(2) *Restorative Justice: An International Journal* 256, 267.

Within Victoria, the Victorian Institute of Forensic Mental Health (Forensicare) delivers both inpatient and community specialist forensic mental health services. Forensic mental health is an area that aims to meet the needs of people who have offended, or who are deemed to be at risk of offending.¹⁰ Thomas Embling Hospital (TEH) is a 116-bed secure hospital for persons from the criminal justice system who are in need of psychiatric care. TEH also has patients from the public mental health system who require specialised management and treatment. TEH patients may be on one of the following orders: a Custodial Supervision Order (CSO), where a person is found not guilty of a crime due to 'mental impairment' under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic); a Secure Treatment Order (STO); or an Inpatient Treatment Order (ITO). Both STOs and ITOs are made under the *Mental Health Act 2014* (Vic). Services in forensic mental health settings centre around clinical assessment, treatment and rehabilitation for people with serious mental illness and offending behaviours.

2D Why implement RJ in forensic mental health settings?

Historically, people with serious mental illness have not been included in RJ practices in the adult criminal justice system.¹¹ Typically, arguments against their inclusion hinge on the assertion that people with mental illness do not possess the capacity to meaningfully and effectively participate. More recently however, Hafemeistar, Garner & Bath (2012) have argued that there are no conceptual obstacles that prohibit the use of RJ with people with serious mental illness.¹² In fact, RJ interventions are 'needed and timely' to respond to the concerning increase in the number of offenders with serious mental illness being processed through the criminal justice system. Garner & Hafemeister (2003) similarly argue that offenders with mental illness should not be denied the opportunity to participate in RJ interventions, as there exist significant benefits for victims, offenders and the broader community that are worthwhile pursuing.¹³

¹⁰ Department of Health & Human Services, 'Forensic mental health services', *Victoria State Government* (Website, 2017)

<[https://www2.health.vic.gov.au/mental-health/mental-health-services/services-by-type/forensic-mental-h
ealth-services](https://www2.health.vic.gov.au/mental-health/mental-health-services/services-by-type/forensic-mental-health-services)>

¹¹ Marian Liebmann, *Restorative Justice: How It Works* (Jessica Kingsley Publishers, London, 2007).

¹² Thomas Hafemeister, Sharon Garner & Veronica Bath, 'Forging Links and Renewing Ties: Applying the Principle of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder' (2012) 60 *Buffalo Law Review* 147, 206.

¹³ Sarah Garner & Thomas Hafemeister, 'Restorative justice, therapeutic jurisprudence and mental health courts: Finding a better means to respond to offenders with a mental disorder' (2003) 22 *Mental Health Law* 1.

According to Drennan, Cook & Kiernan (2016), the slow development of RJ in forensic mental health services is ‘counterintuitive’, given the strong theoretical compatibility between restorative principles and principles of treatment and rehabilitation in therapeutic settings.¹⁴ Forensic mental health services have the dual aim of improving mental health and reducing risk.¹⁵ In a similar vein, RJ interventions, which involve addressing, repairing and taking accountability for harm, may be able to positively contribute to a patient’s therapeutic progress. A study undertaken by Cook, Drennan & Callanan (2015) makes a small-scale, albeit very significant contribution to the evidence base on this topic through a qualitative study on RJ in forensic mental health settings.¹⁶ The study reveals high levels of satisfaction for victims and offenders and confirms that it is possible to conduct a safe, structured RJ intervention in forensic mental health settings. The study found that RJ ‘complemented and contributed’ to the underlying therapeutic goals of the forensic service.¹⁷

Victims of violent crimes committed by people with serious mental illness may have significant and complex justice needs. When a person who caused harm is deemed to be ‘not guilty by reason of mental impairment’, victims may be left with feelings of confusion, anger or distress that the person has not been held accountable. Michael Power, in his 2016 Churchill Fellowship on victims of serious violence committed by people with mental illness, identifies the unique experience of such victims. Victims may be left with unanswered questions about why the violence occurred, or what treatment is being provided by the mental health service to prevent the violence from happening again.¹⁸ There is a complex interplay of tensions between the needs of victims, the needs of forensic patients, the response from the criminal justice and forensic mental health systems, and the response from the broader community.¹⁹ This report explores the possibility of RJ practices as a first step towards addressing the complex needs of victims, patients and the broader community.

¹⁴ Gerard Drennan, Andy Cook & Henry Kiernan, ‘The Psychology of Restorative Practice in Forensic Mental Health Recovery’ in Theo Gavrielides (eds), *The Psychology of Restorative Justice: Managing the Power Within* (Taylor & Francis Group, 2016) 127.

¹⁵ Andy Cook, ‘Restorative practice in a forensic mental health service: three case studies’ (2019) 30 (5) *The Journal of Forensic Psychiatry & Psychology* 876, 876.

¹⁶ Andy Cook, Gerard Drennan & Margie Callanan, ‘A qualitative exploration of the experience of restorative approaches in a forensic mental health setting’ (2015) 26(4) *The Journal of Forensic Psychiatry & Psychology* 510.

¹⁷ Ibid 523.

¹⁸ Michael Power, ‘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 - Canada, the USA, UK and The Netherlands’ (Report, The Winston Churchill Memorial Trust, 2016) 1.

¹⁹ Ibid 3.

In addition, a forensic patient may identify individual benefits from engaging in a restorative intervention. According to Dorkins & Adshead (2011), RJ can offer a forensic patient an opportunity to reconstruct an identity that is not solely defined by their illness and the offence.²⁰ In the aftermath of an offence, a forensic patient creates an ‘offender identity’, which is maintained by the narrative of the forensic experience.²¹ RJ interventions may assist a patient to discover an identity that at once acknowledges the incident and the impact of the harm on another, all the while reengaging with an identity that is not solely based on the one incident. For some forensic patients, there may be a genuine lack of understanding of the impact of the harm, as current structures in forensic institutions may not provide opportunities for patients to hear, understand and account for the impact of the harm caused.²² The literature indicates that taking ownership for actions and recognition of harm are an integral part of the recovery process for a forensic patient.²³

Restorative interventions have also been identified as an option to address incidents or threats of harm in forensic mental health services between staff and patients. According to Leeuwen & Harte (2011), instances of severe violence against staff in psychiatric inpatient institutions are high.²⁴ Evidence from the Prince Charles Hospital Secure Mental Health Rehabilitation Unit (SMHRU) in Brisbane reveals 18 incidents of harm between July 2016-January 2018.²⁵ While research into the use of RJ practice in this context is still new, preliminary views taken by service professionals indicate positive outcomes.²⁶ RJ practices may present an opportunity to supplement existing processes in forensic mental health settings to improve long-term outcomes for staff and patients.

3 Practice considerations

3A Capacity and participation

²⁰ Eluned Dorkins & Gwen Adshead, ‘Working with offenders: challenges to the recovery agenda’ (2011) 17 *Advances in Psychiatric Treatment* 178, 182.

²¹ Ibid.

²² Power (n 18) 7.

²³ Ibid 10.

²⁴ Mirjam van Leeuwen & Joke Harte, ‘Violence against care workers in psychiatry: Is prosecution justified?’ (2011) 34 *International Journal of Law and Psychiatry* 317, 317.

²⁵ Queensland Health Victim Support Service, ‘Restorative Practice in Extended Care and Community Mental Health at the Prince Charles Hospital’ (Summary Model, Queensland Health, version updated 13 July 2020) 3.

²⁶ James Tapp, Estelle Moore, Mary Stephenson & Davina Cull, “The image has been changed in my mind”: a case study of restorative justice in a forensic mental health setting’ (2020) *The Journal of Forensic Practice* 1, 2; Cook, Drennan & Callanan (n 16).

A significant obstacle for development of RJ in forensic mental health settings has been the widely held belief that patients would not have the mental capacity for empathy, accountability and moral responsibility.²⁷ Scepticism is also expressed around a patient's capacity to effectively participate at a more practical level.²⁸ This assumption has since been challenged. According to Cook (2019), 'the majority of patients with mental illness who have offended are able to engage in treatment including relapse prevention work'.²⁹ Mental health is not a fixed state; and participation may be able to occur despite the presence of some symptoms of psychosis.³⁰ Consideration must be given to *how* an assessment of capacity is made; *who* makes this assessment of capacity; and whether a capacity determination can change (to correspond with the fluidity of mental health). In addition, it is important to consider underlying principles that may guide a capacity assessment to align the process with the principles that underpin restorative justice, such as self determination, equality and human rights.³¹

It is important to identify who is responsible for making a capacity assessment. According to Power (2017) in conversation with Dr Andy Cook, cases referred to a RJ process should be taken to the multidisciplinary treating team for a clinical opinion on how the practice could fit in with the ongoing work with that patient.³² A final assessment regarding the patient's capacity to consent and engage would then be made by the team.³³ When making this decision, there will be no 'bright line' to delineate between capacity and incapacity. Capacity is not a fixed condition and is influenced by a range of factors and settings.³⁴ Cook, Drennan & Kiernan (2015) discuss one patient's ability to engage in an RJ intervention despite simultaneously experiencing symptoms of psychosis.³⁵ This suggests that the question before the treating team is not necessary whether or not the patient has capacity to participate, but how can the patient be supported to ensure they have the best possible chances of participating?

A key issue in a capacity assessment includes the patient's capacity for empathy. If a patient has very low empathy, or no empathy, they may be inappropriate for a RJ

²⁷ Drennan, Cook & Kiernan (n 14) 130.

²⁸ Liebmann (n 11).

²⁹ Cook (n 15) 876-877.

³⁰ Power (n 18) 10.

³¹ Mary Condell, 'Capacity to Mediate and the Human Right to Self Determination: The Mediator's Responsibility!' (2009) 2(1) *Journal of Mediation & Applied Conflict Analysis* 211.

³² Michael Power, 'Churchill Fellowship - meeting notes, observations and reflections' (Report, The Winston Churchill Memorial Trust, 2017) 34.

³³ Cook, Drennan & Callanan (n 16) 513.

³⁴ Susan Crawford, Lewis Dabney, Judith Filner & Peter Maida, 'From determining capacity to facilitating competencies: A new mediation framework' (2003) 20(4) *Conflict Resolution Quarterly* 385, 392.

³⁵ Cook, Drennan & Callanan (n 16) 519.

intervention.³⁶ Similarly, a patient's capacity for 'mentalising' (that is, the ability to recognise the emotional state of another) cannot be assumed.³⁷ On the other hand, some forensic mental health patients may be able to recognise empathy, but will be unable to demonstrate it.³⁸ According to Power (2017), patients must also possess resilience to manage the reintegrative shaming element of the process and to be able to hear the impact of their harm and handle the accompanying emotions.³⁹ For some forensic patients, there may be paranoia, underlying anxiety, hyperactivity or impulsivity, all of which may affect a patient's participation in a restorative conference. Ultimately, the treating team will weigh up all relevant factors when making an assessment of capacity and competence and will make their decision in line with institutional procedures and processes.

A capacity assessment within a forensic institutional setting will necessarily revolve around managing risk and ensuring security as paramount considerations. This is a practical reality of all decision-making that takes place in secure settings. However, this report also situates a capacity assessment in the context of the grounding, underlying principles of restorative justice, such as relationship, voice, participation and informed, consensual decision-making.⁴⁰ To presume that a person lacks capacity and to refuse a restorative intervention on this basis, may deny human rights and access to justice.⁴¹ At its core, a restorative justice philosophy aims to do things 'with', rather than 'for' and 'to' individuals.⁴² This will be impossible where risk-averse decision-making affects the very possibility of a patient being *offered* a restorative process.

3B Complexity and comorbidity

Working with patients that have mental illness and cognitive impairment issues will require strong collaboration with internal assessment, support and treatment teams. There may be existing support at the institution for patients with intellectual or behavioural disorders, which could be utilised and adapted to assist with any restorative intervention. It is acknowledged that such matters necessarily have an added layer of complexity when considered in the context of an RJ intervention. There may be

³⁶ Power (n 32) 29.

³⁷ Ibid 30.

³⁸ Ibid.

³⁹ Ibid 35.

⁴⁰ Jane Bolitho, 'Chapter 11 Complex cases of restorative justice after serious crime: Creating and enabling spaces for those with a disability' in Theo Gavrielides (eds), *Routledge international handbook of restorative justice* (Taylor & Francis Group, 2018) 160.

⁴¹ Condell (n 31) 211.

⁴² See the 'Social Discipline Window' in Ted Wachtel, *Real Justice. How we can revolutionize our response to wrongdoing* (The Piper's Press, Pipersville PA, 1997).

instances where the complexity of the case is so significant that the safe participation in a RJ process becomes impossible. In these instances, a conference should not proceed. However, it is worth acknowledging that where a RJ participant has a physical disability, such as a mobility impairment that requires wheelchair access, or where a participant is hard of hearing, these physical disabilities are accommodated to the greatest degree possible to enable participation. It follows that strategies may be implemented in RJ practices to support participation for a patient where capacity is in question due to complex mental and/or cognitive impairment issues.

Burnett and Thorsborne (2015) discuss potential challenges for the RJ process for people with 'special needs', including ADHD, autism spectrum disorder, foetal alcohol spectrum disorder, intellectual disability and communication difficulties.⁴³ Overarchingly, the challenges can be broken down into issues of communication, cognition and behaviour. For some, this might mean that information is processed slowly; for others there might be trouble with ordering thoughts, leading to interruptions and impatience. For some, environmental simulations may be so great that concentration is near impossible; and for others anxiety might make any type of communication impossible. According to Bolitho (2018), disability may also impact the 'affect' of an individual, including, for example, a lack of visible emotion; a lack of eye contact; or repetitive or involuntary movements of the body.⁴⁴ Burnett and Thorsborne (2015) offer a range of strategies for practitioners operating in this area, including the use of storyboards, visual props and providing additional time to process conversation.⁴⁵ Adjustments in the script may include shortening and simplifying language, avoiding slang or jargon and asking more directed and close-ended questions.⁴⁶ In certain circumstances, it might be more appropriate to use restorative conversations, as opposed to conferences.

3C Role of the facilitator

The requirement for a high level of skill in the RJ facilitator is consistent across all literature on RJ in forensic mental health settings.⁴⁷ According to Cook (2019), while it may appear at a superficial level that the role of the facilitator is simply to signpost the process through the use of key questions, active listening and massaging the process

⁴³ Nick Burnett & Margaret Thorsborne, *Restorative Practice and Special Needs: A Practical Guide to Working Restoratively with Young People* (Jessica Kingsley Publishers, London, 2015).

⁴⁴ Bolitho (n 40) 162.

⁴⁵ Burnett & Thorsbore (n 43) 63.

⁴⁶ Ibid 142-150.

⁴⁷ Cook, Drennan & Callanan (n 16) 519; Cook (n 15) 889; Drennan, Cook & Kiernan (n 14) 136; Power (n 32) 34; Power (n 18) 16.

towards a (potentially) restorative conclusion, the role is in fact, far more complex.⁴⁸ Of particular importance are skills relating to containment, engagement and assessing risk.⁴⁹ The facilitator is tasked with creating a sense of trust and safety for all participants. Drennan, Cook & Kiernan (2016) assert that psychological containment is the primary task here. Strategies to achieve this goal may include creating protocols and guidelines for anxiety-inducing situations.⁵⁰ Preparation and planning are fundamental to calming fears around participation.

According to Power (2017), it is best practice to use a model of co-facilitation, with both an external facilitator (contracted from a restorative justice service) and an internal facilitator (staff member), who has an existing relationship with the patient.⁵¹ It is useful for forensic settings to develop and maintain partnerships with external restorative justice services to enable the co-facilitation model. An external facilitator will be able to bring RJ expertise and impartiality, while an internal facilitator may be a source of familiarity for the participating parties. An internal facilitator will also have specific mental health knowledge and an understanding of the policies and procedures of the service. In the Sussex NHS program implementation, the treating psychiatrist made the final decision about whether the restorative intervention was either single or co-lead.⁵² Where possible, the co-facilitation model is the preferable option. This importance of an appropriate model of facilitation can be paralleled to the context of RJ in sexual or family violence, where facilitators are required to have an awareness of the dynamics of family violence, and in addition, participants are supported by a person who is an expert in the field and has knowledge of RJ processes. Despite the diversity of contexts here, the model of facilitation is fundamentally important for the overall success and safety of both RJ processes.

3D Support persons

For all restorative justice conferences that will be discussed (patient-patient, patient-staff, family group conference and patient-victim of index offence), all participants should be encouraged to explore options for appropriate support during the conference. It is crucial however, that supporters are fully informed of their role in the conference and how the process will unfold, so as to avoid any potential for disruptions or derailment.⁵³ Consumer input into the Brisbane model has indicated that it is

⁴⁸ Cook (n 15) 889.

⁴⁹ Cook, Drennan & Callanan (n 16) 519.

⁵⁰ Drennan, Cook & Kiernan (n 14) 136.

⁵¹ Power (n 32) 27.

⁵² Power (n 32) 34.

⁵³ Queensland Health Victim Support Service (n 25) 14.

important for there to be a separation between the patient support person and the treating team; ideally the patient can choose who the support person is.⁵⁴ In a case study reported by Tapp et al (2020), Sarah, the staff member harmed, was supported by a member of the victim care unit team, Emma.⁵⁵ Emma was actively engaged throughout the process, which included visits to Sarah's house during preparation (with permission). Emma supported Sarah in moments of distress during the conference, and Emma travelled to and from the meeting location with Sarah. Additionally, during the conference, Emma was invited by the facilitators to comment, which she did so by asking Joe (the patient who caused the harm) a question in her capacity as Sarah's supporter.⁵⁶ Sarah was able to debrief with Emma (in addition to the facilitators) in the immediate follow up and again two months after the intervention. This case study highlights the potential importance of a support person as an additional pillar of strength for the person harmed, during a highly emotional experience.

3E RJ intervention and the criminal justice system

It is crucial that all parties involved (service staff, participants and facilitator) in any kind of RJ intervention are aware of how the intervention will interact with any concurrent criminal justice process. According to Leeuwen & Harte (2011), while incidents of severe violence against staff in psychiatric institutions are high, victims rarely make police reports.⁵⁷ Further, even if reports are made, prosecution and conviction are rare.⁵⁸ However, this will not be true for every incident of violence, and nor should it be the expectation. Thus, the implications of any restorative intervention must be clear to all parties from the outset, to avoid misunderstandings. As an example, in one of the case studies in Cook (2019), Pat (the patient who caused harm) argued through her lawyer that she should not face legal consequences for her actions in a criminal court because of her participation in a restorative conference. Pat was under the mistaken impression that the restorative intervention was instead of the criminal justice process. Cook (2019) states that this was not the intention of the intervention and their restorative policy has been amended to ensure that patients are clear henceforth.⁵⁹

3F When might a restorative process not be suitable?

⁵⁴ Ibid.

⁵⁵ Tapp et al (n 26).

⁵⁶ Ibid 7.

⁵⁷ Leeuwen & Harte (n 24) 317.

⁵⁸ Ibid.

⁵⁹ Cook (n 15) 883.

While suitability for a restorative intervention will be determined on an individual case-by-case basis, the literature suggests that certain exclusion criteria do exist. If a person is found not guilty by reason of mental impairment, the question follows: why should they take responsibility for the harm that has been caused? According to Power (2016) while a patient will not take legal responsibility for the harm caused, there will be important benefits for a patient to take accountability for their past actions, and responsibility for actions going forward.⁶⁰ It follows that where a patient is denying the incident or minimising the impact of harm, they will not be suitable for a restorative intervention. Other examples where participation is not suitable were identified in the Brisbane model and include: where the process is not voluntary; where participation is driven by an intention to threaten, harm, humiliate, undermine, aggravate, or gain perceived benefits (such as leave entitlements); where there are domestic violence concerns; or where the treating team deems the patient fundamentally unsuitable.⁶¹ Power (2016) also indicates that patients with long-term rehabilitative needs might not be suitable for an RJ intervention during the initial post-offence period.⁶²

4 Challenges and conflicts between RJ and forensic treatment approaches

4A Cultural shift: Role of MH staff

To implement RJ practices into forensic mental health settings, there may be a cultural shift that needs to take place in forensic institutions generally. Cook, Drennan & Callanan (2015) quote a facilitator stating, ‘There’s been a quite defensive response to the idea of doing that a bit differently, from some quarters’.⁶³ For forensic service staff to participate as a victim in a restorative process, they necessarily step out of a professional role and assume a position of vulnerability.⁶⁴ For staff harmed, their professional self may be used as a layer of protection or control in such a challenging environment. Thus, staff members may be reluctant to relinquish this identity or to place themselves in a position where self-preservation becomes more difficult.⁶⁵ Additionally, there may be hesitation to talk about an incident of harm if it will be perceived as ‘weak’ or expose them to the risk of further harm.⁶⁶ In this way, a restorative process may feel

⁶⁰ Power (n 18) 10.

⁶¹ Queensland Health Victim Support Service (n 25) 19-20.

⁶² Power (n 18) 18.

⁶³ Cook, Drennan & Callanan (n 16) 517.

⁶⁴ Power (n 32) 34.

⁶⁵ Cook, Drennan & Callanan (n 16) 526.

⁶⁶ Ibid 518. A staff member harmed was quoted in the study saying ‘it’s a difficult thing to do as a professional with a patient...you don’t know whether she’s sitting there thinking ‘Ooo what a wimp’’.

'counterintuitive' for some,⁶⁷ as it ruptures the power dynamic between patient and staff. Staff in forensic settings have been trained to maintain clear boundaries with patients and where necessary, to keep disclosure of personal information to a minimum.⁶⁸ It will be important for staff to recognise circumstances where a face-to-face restorative process will be useful, and where it might be 'risky and potentially destabilising'.⁶⁹

4B Managing risk

In secure forensic settings, a primary, if not paramount consideration for service staff will be the successful management of risk. Considerations of risk will not eliminate the possibility of an RJ intervention, but if not kept in check, they could translate into over-control and a concentration of custodial thinking. In the UK, the DoH has developed the *See Think Act* framework to manage 'relational security' as a mechanism to balance all relevant considerations of risk when making decisions in secure settings.

⁷⁰ According to *See Think Act*, risk may be managed by balancing three separate, but interrelated aspects of security: **relational security** (day-to-day dynamics in the interaction between patient and staff); **procedural security** (service policies and practices used to maintain security and safety); and **physical security** (tangible boundaries, such as locks, fences, alarms). The underlying premise of the guideline is that it is possible to maintain vigilance and security, whilst also promoting recovery. Analysing security and risk in the context of forensic settings necessarily involves accepting a culture of control, as the idea of a loss of control may be unbearably anxiety-inducing for staff.

In forensic settings, boundaries are enforced strictly to ensure the safety of patients, as well as the safety of others. However, Barker (2012) explores the boundaries that are placed around risk in forensic settings and questions when such boundaries become counter-productive:

'Clearly harmful behaviours are to be avoided, but how far should the process by which risk is managed in secure services influence the longer-term recovery of patients? Does it in fact reduce risk? Or does the emphasis towards risk and away from recovery result in some patients becoming stymied in their recovery in the name of risk management, and does this in turn have the potential to actually increase their risk?'⁷¹

⁶⁷ Cook (n 15) 889.

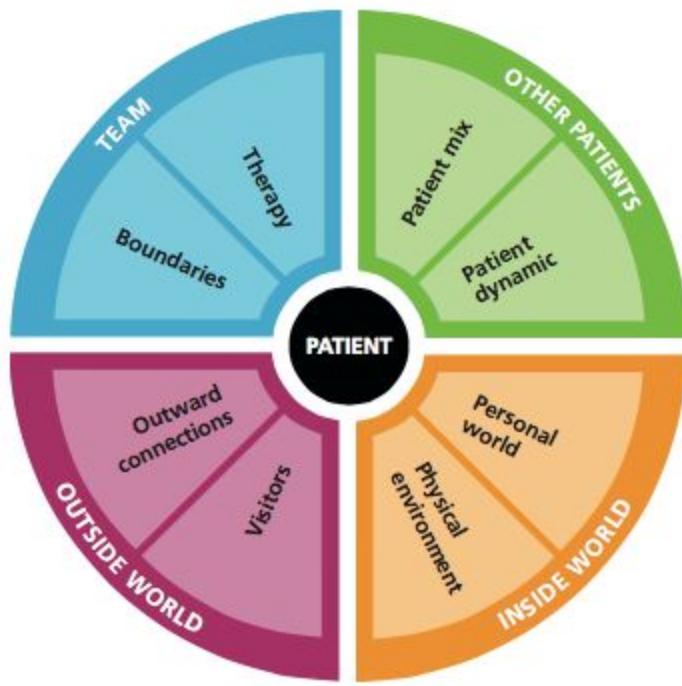
⁶⁸ Drennan, Cook & Kiernan (n 14) 136.

⁶⁹ Ibid.

⁷⁰ Department of Health, *See Think Act: Your Guide to Relational Security* (Report 2010).

⁷¹ Richard Barker, 'Recovery and risk: Accepting the complexity' in Gerard Drennan & Deborah Alfred (eds), *Secure recovery: Approaches to recovery in forensic mental health settings* (Willan Publishing, 2012) 29.

While the attempt to control risk is always located with the patient, Barker (2012) states that the risk is never fully ‘owned’ by the patient. The risk is owned by professionals: the service, nursing staff or clinical team, which may be disempowering for a patient and counterproductive to their recovery. On the other hand, Barker (2012) states that the promotion of recovery should never be an excuse for failing to ensure the safety of



patients, staff, family members and the community.⁷² A degree of control will always be necessary in secure settings, particularly when patients are experiencing heightened or distressing mental health symptoms. Ultimately, managing risk is a balancing act; one that will be constantly juggled in any restorative justice intervention in a forensic setting.

Figure 1: Relational Security Explorer adapted from See Think Act

4C Offender rehabilitation & reduced recidivism

Literature emanating from New Zealand challenges the ability of RJ to meet the rehabilitative needs of complex, high-risk offenders such as forensic patients.⁷³ More specifically, Ward, Fox & Garber (2014) assert that the link between RJ and offender rehabilitation theory and practices are ‘weak, contingent and unsystematic’.⁷⁴ While the authors concede that RJ may have a role as a complementary rehabilitative

⁷² Ibid 30.

⁷³ Tony Ward, Kathryn Fox & Melissa Garber, ‘Restorative justice, offender rehabilitation and desistance’ (2014) 2(1) *Restorative Justice: An International Journal* 24.

⁷⁴ Ibid 33.

intervention, they caution against sweeping claims of efficacy in offender recidivism reduction, such as those promulgated in Morris (2002).⁷⁵ Relevantly, in the three case studies explored in Cook (2019), at least one RJ conference was followed by another incident of patient violence. In the case study where Toni (patient who caused the harm) assaulted Sally (staff member harmed) on the ward, despite the initial reported success of the RJ conference, Toni was violent again and was transferred to a high security ward. During Cook's discussion/evaluation, Cook states, 'In terms of recidivism, perhaps the most highly valued outcome, the meeting was ineffective'.⁷⁶

4D Victim or offender needs

Throughout a RJ process in a forensic setting, it is crucial to consistently return to the question: Are the needs of *both* parties being considered and responded to? Forensic mental health settings are therapeutic services that offer specialised care and programs that aim to facilitate the recovery of patients. An RJ intervention would no doubt align with such service aims. At the same time, it is crucial that the recovery needs of the person that caused harm are not prioritised at the expense of the restoration needs of the person harmed.⁷⁷ As forensic institutions are typically focused on ensuring that patients are at the centre of therapeutic interventions, it may be a paradigm shift to instead, re-centre the victim. According to Power (2016), staff members that participate as victims in a restorative justice intervention must be able to identify a tangible benefit for themselves, beyond that of the recovery needs of the patient.⁷⁸

4E RJ is not a 'quick fix'

According to Cook (2019), there is evidence to suggest that restorative interventions can help to maintain the therapeutic functioning of secure wards.⁷⁹ In this way, restorative interventions may act as a supplementary tool for supporting staff and patients. However, restorative interventions must not be used as a 'quick fix' to justify transferring patients back to a ward where a staff member that has been harmed works.⁸⁰ One case example in Cook (2019) involved Jessie (patient who caused the harm) and Jen (staff member harmed) and an incident on a low security adult ward.⁸¹ When Jen

⁷⁵ Allison Morris, 'Critiquing the Critics: A Brief Response to Critics of Restorative Justice' (2002) 42(1) *The British Journal of Criminology* 596.

⁷⁶ Cook (n 15) 888.

⁷⁷ Drennan, Cook & Kiernan (n 14) 139.

⁷⁸ Power (n 18) 16.

⁷⁹ Cook (n 15) 890.

⁸⁰ Power (n 18) 16

⁸¹ Cook (n 15) 883.

was initially approached to participate in the RJ conference, she felt that the intervention was offered as ‘tokenistic support’ and a cover-up for the unspoken plan to transfer Jessie back to the low security ward where Jen worked, following the ‘restoration’ of the relationship.⁸² Jen expressed feeling concerned and frightened that Jessie would be transferred and that Jen would be powerless to influence this.⁸³ The author (Cook) and RJ facilitators addressed Jen’s concern by assuring her that decisions made about Jessie’s care plan were independent of the restorative intervention.

5 Strategies to overcome challenges

5A Creating organisational and culture change

Key strategies to embed RJ into forensic services may help to mitigate cultural and institutional resistance. The RJ program at the John Howard Centre, East London, NHS Trust had significant challenges due to: a lack of promotion within senior management, the absence of RJ champions within the service, and the failure of the service to develop partnerships with other services.⁸⁴ According to Power (2016), support from senior clinical and executive personnel is crucial, as well as information awareness and education for all other staff, families and patients.⁸⁵ Importantly, the successful implementation of a program cannot rely on a few people. There must be a cultural and environmental shift in the service. This will be aided by ‘a formal referral process, supervision structure, and administrative support for data collection and recording the outcomes for each referral’.⁸⁶ Key learnings have emanated from Brisbane, where restorative practice has been implemented in the Secure Mental Health Rehabilitation Unit (SMHRU) at The Prince Charles Hospital (TPCH). The success of this program was made possible by gaining support from key areas of the service.

RJ was embedded at every level of TPCH. For example:

- The **Restorative Practice Steering Committee**, which is chaired by the Hospital Operations Director, maps the strategic direction of restorative practice in TPCH.
- The **Restorative Practice Support Team** operationalises restorative practice in the TPCH mental health.

⁸² Ibid 884.

⁸³ Ibid 885.

⁸⁴ Power (n 32) 34.

⁸⁵ Power (n 18) 19.

⁸⁶ Power (n 32) 34.

- **Restorative Practice Links Team** supports and encourages the use of restorative practice, Restorative Dialogue, Circles and support information for participation in Restorative Meetings.
- **Restorative Practice Evaluation Group** supports the external evaluation of restorative practice on the SMHRU.⁸⁷

5B Building links between justice needs and the recovery model

At its core, RJ as a therapeutic response in a forensic mental health setting, must be understood to fit within a broader journey of recovery. As mentioned in Section 2B, restorative justice has the potential to meet justice needs that are typically left unmet by the criminal justice system, including voice, participation, accountability and relationship. As a result, restorative justice interventions have the potential to shift focus from the risk-averse framing of ‘the forensic patient’, to reorient towards potential outcomes that are underpinned by a model of recovery. Recovery as a service approach within forensic mental health settings, may require system changes at every level of an organisation, in order to be fully embraced.⁸⁸ Importantly, forensic mental health services cannot ‘do recovery to’ individuals.⁸⁹ What a service can do however, is create an environment that is capable of fostering an individual’s recovery.⁹⁰ According to Allott et al (2002), services must adopt a response that is positive, empowering, respectful and facilitating.⁹¹ Similarly, Maylea (2017) states that the ascendent recovery approach requires a shift away from ideas of treatment underpinned by involuntarism and coercion, and towards those that are fundamentally person-centred.⁹²

By understanding mental health recovery to be a process, rather than a destination (as proposed in the recovery approach),⁹³ a RJ intervention may be seen as a singular (albeit potentially significant) step along the way in a patient’s journey of recovery. In the

⁸⁷ Queensland Health Victim Support Service (n 25) 5.

⁸⁸ Gerard Drennan, Kate Law & Deborah Alred, ‘Recovery in the forensic organisation’ in Gerard Drennan & Deborah Alred (eds), *Secure recovery: Approaches to recovery in forensic mental health settings* (Willian Publishing, 2012) 68.

⁸⁹ Ibid 55.

⁹⁰ Ibid.

⁹¹ Piers Allot, Linda Loganathan & Bill (KWM) Fulford, ‘Discovering hope for recovery: a review of a selection of recovery literature’, 21(3) *Canadian Journal of Community Mental Health* 1.

⁹² Christopher Maylea, ‘A rejection of involuntary treatment in mental health social work’ (2017) 11(4) *Ethics and Social Welfare* 336.

⁹³ Tim Thornton & Peter Lucas, ‘On the very idea of a recovery model for mental health’ (2010) 37 *Journal of Medical Ethics* 24.

recovery model, a ‘step-back’ in a patient’s mental health progress is not a ‘failure’, but an opportunity to build resilience and strength along the course of one’s life journey. In her seminal 1996 work ‘Recovery as a Journal of the Heart’, Deegan highlights the importance of choice in recovery: ‘Staff must...continue to offer options and choices even if they are rejected over and over again’.⁹⁴ Choice, participation and voice are not only features of the recovery model, but are often cited ‘justice needs’ for parties to a harm, which indicates the links between the recovery model and the justice needs met by a restorative intervention. Similarly, offering processes underpinned by principles of voluntariness as alternative ways of responding to harm may provide forensic patients with a greater sense of agency, choice and control. Of course, forensic services must strike a balance between risk management and providing therapeutic opportunities for patients that promote recovery. It is acknowledged that an unbalanced prioritisation of recovery may lead to unsafe outcomes. However ultimately, re-centering the importance of recovery may help to overcome the challenges that threaten the implementation of RJ in forensic mental health settings.

5C Keeping the CRPD front and centre

A mechanism to assist in attaining recovery-based outcomes for forensic patients, is to consider, and commit to, the obligations set out under the *Convention on the Rights of Persons with Disabilities 2007* (the ‘CRPD’).⁹⁵ A commitment to adherence with the CRPD obligations necessarily involves ensuring equal access to justice processes, such as restorative justice interventions. Despite the limitations that may be ascribed by other legal and non-legal models of capacity, a commitment to the CRPD ensures access to opportunities for participation on the basis of choice and agency. Art 3 stipulates that the general guiding principles of the CRPD include respect for dignity, including autonomy to make one’s own choices;⁹⁶ non-discrimination;⁹⁷ full, effective and inclusive participation in society;⁹⁸ equality of opportunity;⁹⁹ and accessibility.¹⁰⁰ Access to justice is specifically outlined in art 13, which states that persons with disabilities should be given access to justice processes on an equal basis with others, which involves any necessary accommodations to ensure effective participation. Read in

⁹⁴ Patricia Deegan, ‘Recovery is a Journey of the Heart’ (1996) 19(3) *Psychiatric Rehabilitation Journal* 91.

⁹⁵ Note, art 1 of the CRPD outlines the inclusion of persons with long-term mental impairment as a person with disability.

⁹⁶ Art 3(a) CRPD.

⁹⁷ Ibid art 3(b).

⁹⁸ Ibid art 3(c).

⁹⁹ Ibid art 3(e).

¹⁰⁰ Ibid art 3(f).

conjunction with the underlying principles of the *CRPD*, art 13 unambiguously supports the proposition that a service should provide their patients with the opportunity to choose (or decline) to participate in a restorative justice process. The *CRPD* offers a forensic mental health service the opportunity to comply with obligations stipulated by an international Convention to which Australia is a signatory. Services should keep these obligations front and centre, particularly regarding decision-making for patients on whether or not they are entitled to access a justice process such as RJ.

6 Examples of application

Examples of RJ programs that have been implemented in forensic mental health settings can be found both internationally and domestically. However, these programs are sparse, in early stages of implementation and are largely confined to the context of patients who caused harm and staff harmed.¹⁰¹ At the time of writing this report, access to evaluations of programs was not possible. The evidence-based in this context is largely confined to case studies, qualitative research designs and reports. This section will map existing RJ programs in forensic mental health settings and provide brief points on the implementation, training and challenges for each program. This information has been adapted from Michael Power's Churchill Fellowship program notes and observations, which provides a detailed summary of Michael's overseas travels to the United Kingdom, the Netherlands, USA and Canada and his meetings with key stakeholders in the programs.

6A United Kingdom

Forensic and Specialist Services, Kent and Medway NHS

Implementation	Training	Challenges	Considerations
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¹⁰¹ Cook, Drennan & Callanan (n 16); Cook (n 15); Tapp et al (n 26).

<p>RJ program commenced in November 2016. RJ was used to respond to violence between forensic patients and staff (where forensic patients have mental health diagnosis and/or mild to moderate intellectual disability). All patients admitted to the units have a history of offending.</p>	<p>The service trained 12 staff members to be RJ facilitators (including a combination of social workers, psychologists, psychiatrists and nurses).</p> <p>Restorative Justice Champions were trained across the service to promote the use of RJ and support the education of all staff. This was a strategy to develop organisation-wide ‘buy-in’.</p>	<p>Adapting RJ practices for persons who present with disinhibited behaviours (e.g emotional regulation) and for adults with learning disabilities.</p> <p>Additionally, it has been a challenge for the service to respond to referrals promptly.</p>	<p>It is recognised that it is not always possible to reach a restorative conference on the ward. All staff are being trained in implementing restorative conversations. There is an aim to develop Restorative Wards, where RJ practice is imbued as an ethos on the ward.</p>
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Forensic Healthcare Services, Sussex NHS Partnership:

Implementation	Training	Challenges	Considerations
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RJ program commenced in the Sussex NHS in 2012 in Hellingly (medium secure service). This was the first forensic mental health service in the UK to adopt restorative processes. The program is currently being led by Dr Andy Cook (psychologist).	Ten staff across different units were trained by Henry Kiernan (external RJ facilitator and trainer).	Changes to staff slowed implementation; creating cultural change in relation to RJ was slow. There has been no evaluation of the implementation to date.	Eligible examples of situations where RJ is used: patient to patient violence; and patient to staff violence. Aim to expand to forensic patients and external victims. Developing partnerships outside the service is important for successful implementation.
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John Howard Centre, East London NHS Trust:

Implementation	Training	Challenges	Considerations
Implementation in this service proved to be challenging; at the time Power met with Dr Miloni Patel (psychologist), it had made little progress since its commencement in January 2016 A small-scale pilot program was undertaken across 6 wards.	6 mental health service staff were trained as RJ facilitators (social workers, psychologists and psychiatrists).	Since its commencement, there had been few referrals and no RJ process had progressed to conference; there were not enough RJ champions in the service, particularly at the executive and management level. The service had not developed any partnerships outside the Trust.	

Broadmoor Hospital, West London, Mental Health Trust:

Implementation	Training	Challenges	Considerations
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<p>RJ program commenced at Broadmoor Hospital (high secure forensic mental health service) in 2014.</p> <p>Program implementation led by Estelle Moore and Matt Wilding.</p> <p>By 2016, the program was providing RJ processes between patients-patients and patient-staff, and was just beginning to facilitate conferences between patients and victims of the index offence.</p>	<p>Over 30 staff were trained in a one-day training by Henry Kiernan (external facilitator), including a cross section of staff from social work, psychology, psychiatry, nurses, OT and security staff. A second round of training took place in 2015.</p> <p>By 2015, every team in the hospital had a restorative justice champion, who would recommend when restorative approaches may be appropriate and support staff in education and promotion.</p>		<p>Meetings were held with senior staff to get buy-in at executive level.</p> <p>A trust-wide policy was developed to cover safeguards and governance on the restorative interventions.</p>
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6B Canada

Forensic Assessment and Outpatient Services (FAOS), Calgary, Alberta

Implementation
<p>Dr Sergio Santana has developed a family therapy service, which uses a restorative approach in working with family members of forensic patients who have been found to be not criminally responsible. The service also works with victims of violence crimes who were not in a relationship with the patient prior to the incident.</p>

6C Australia

*The Prince Charles Hospital, Secure Mental Health Rehabilitation Unit (SMHRU),
Brisbane*

Implementation	Support	Considerations
Queensland Health Victim Support Service (QHVSS) developed a program of restorative practice in extended care and community mental health at The Prince Charles Hospital (TPCH), which commenced implementation in 2019.	Support for restorative practices was gained at every level through the creation of the RP Steering Committee, RP Support Team, RP Links and RP Evaluation Group.	Eligible instances of harm that can be referred include: physical or verbal harms or threats of harm between patients, staff and carers; historical instances of harm; and harms caused by the actions of patients receiving care within TPCH mental health services.

7 Options for Implementation

There are a range of options for implementation that sit at various points along the 'Restorative Practices Continuum',¹⁰² from informal to formal processes. While formal restorative practices are more structured and may have a significant impact on participants, informal practices can also be hugely impactful, as they are embedded into the ongoing of everyday life.¹⁰³

Options include:

- A. Restorative language (including affective statements and questions)
- B. Restorative Circles
- C. Patient who caused the harm-patient harmed conferences
- D. Patient who caused the harm-staff harmed conferences
- E. Family group conferences
- F. Patient who caused the harm-victim of index offence conferences

¹⁰² The Restorative Practices Continuum has been adapted from Ted Wachtel, 'Defining Restorative' (Report, International Institute for Restorative Practices, 2016).

¹⁰³ Paul McCold & Ted Wachtel, 'Restorative justice in everyday life' in John Braithwaite & Heather Strang (eds.) *Restorative justice and civil society* (Cambridge University Press, Cambridge, UK 2001) 114.

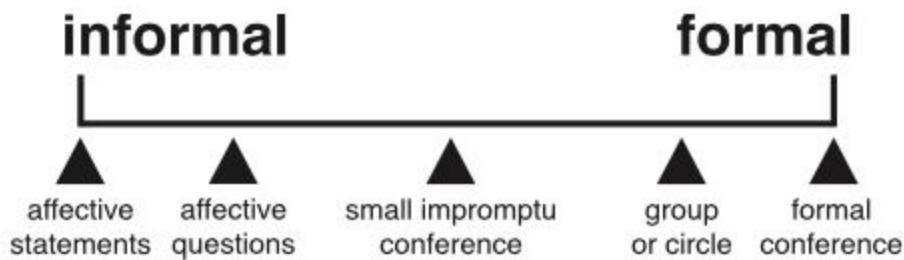


Figure 2: Restorative Practices Continuum

This section introduces each option separately, outlining relevant practice considerations and where appropriate, case studies. This report recommends that any implementation of restorative practice also include overall reflection of the above Practice Considerations [section 3] and Challenges and Conflicts [section 4], in addition to the nuanced considerations of each option. Common amongst all options on the continuum, is that each model involves an encounter between the key stakeholders (person who caused the harm, person harmed and a facilitator) and each model includes potential for a wrong to be articulated and addressed. Additionally, each option requires voluntary participation from all stakeholders.

Introducing the Case Studies

Each RJ conference option that will be explored in this report will include a 'case study' as an illustrative example of how a conference could unfold, including practical examples of relevant considerations, risks and challenges that may arise. The aim of these case studies is to clearly illustrate each RJ option and apply considerations to a practical context. It should be noted from the outset that it was difficult to locate a case study of each RJ option in the available literature. Several case studies on patient who caused harm-staff member harmed conferences (these have been most widely explored in forensic mental health settings) were located,¹⁰⁴ however case studies on a patient who caused harm-patient harmed conference or a patient who caused harm-victim of index offence conference were not. As a result, Case Study 1 (Jamie and Lisa) and Case Study 3 (Eden, Sandra and John) have not been extracted from a single journal article, but created by drawing together extracts from a variety of available resources on

¹⁰⁴ See Cook (n 15); Tapp et al (n 26).

RJ conferences in relevant settings.¹⁰⁵ Case Study 2 (Sarah and Josephine) was wholly adapted from one of Cook's (2019) three case studies, Toni and Sally.

7A Restorative Language

Purpose and Features:

Restorative language can be used at any time in relation to an incident that has occurred on the ward. It may be used proactively (developing and building relationships) or reactively (restorating relationships, repairing harm). Restorative language can be broken down into affective statements, which communicate a person's feelings, and affective questions, which invite persons to reflect on the way their actions have impacted others. Instead of defaulting to a punitive response to address the wrongdoing, the patient is given an opportunity to reflect on their behaviour, make amendments and adjust behaviour in the future.¹⁰⁶ As identified by the Queensland Health Victim Support Service (2019), language shift is the first step of cultural shift; using restorative language daily is encouraged as a means of normalising restorative practice and embedding it on the ward.

Restorative Questions (person who caused harm):

- “What happened?”
- “What were you thinking of at the time?”
- “What have you thought about since?”
- “Who has been affected by what you have done?”
- “What do you think you need to do to make things right?”

Restorative Questions (person harmed):

- “What did you think when you realised what happened?”
- “What impact has this incident had on you and others?”
- “What has been the hardest thing for you?”
- “What do you think needs to happen to make things right?”¹⁰⁷

¹⁰⁵ For example, see Cook, Drennan & Callanan (n 16) 516, which provides a list of RJ interventions discussed by participants in the context of victim of index offence conferences. Case Study 3 (Eden, Sandra and John) was created drawing on 'Incident 9: Index offence of violence towards father'.

¹⁰⁶ Brenda Morrison, 'Regulating safe school communities: Being responsive and restorative' (2003) 41(6) *Journal of Educational Administration* 689.

¹⁰⁷ McCold & Wachtel (n 103) 7.

Restorative language can be used in isolated instances between individuals, or may be used to create a ‘script’ for either an impromptu restorative meeting or in preparation for a more formal restorative conference. The above questions have been found to have value in application to any human interaction, as they provide a ‘relational foundation’ for restorative practice.¹⁰⁸ In this way, the ‘restorative experience’ can be made available to all by virtue of these restorative questions, not only those who participate in a conference.

7B Restorative Circles

Purpose and Features

Circles are a versatile restorative practice that can give individuals an opportunity to speak and listen to each other in an environment of safety, equality and respect. Circles may be used proactively (relationship building) or reactively (to respond to wrongdoing or conflict). Circle approaches first emerged in Native American and First Nation communities in Canada¹⁰⁹ and can be used for a wide variety of purposes, including support, decision-making, conflict resolution, information exchange and relationship development.¹¹⁰ Circle practice may include a sequential format, where one person speaks at a time and the opportunity to talk moves concentrically around the circle. Alternatively, a “talking piece” may be used, which is a small object that is passed between participants when it is their turn to speak, which operates to facilitate equal participation and minimise interruptions. Circles provide an opportunity for participants to feel heard and understood, and to share and connect.

Restorative circles could be used in a forensic mental health setting with patients, staff and family members. In these settings, the facilitator may act as the ‘talking piece’, as they can direct conversation and determine whose turn it is to speak. Restorative circles could also arise as a small impromptu conference, where an incident has brought participants together and restorative questions and statements are used. Such impromptu meetings can respond more quickly to the incident (without the planning and preparation required for formal conferences), whilst still facilitating a discussion on the impact of the harm and options for reparation.

¹⁰⁸ Terry O’Connell, ‘Chapter 28 - The best is yet to come: unlocking the true potential of restorative practice’ in Theo Gavrielides (eds.) *The Routledge International Handbooks of Restorative Justice* (Routledge, 2018) 13.

¹⁰⁹ Howard Zehr, *The Little Book of Restorative Justice* (Good Books, 2015).

¹¹⁰ McCold & Wachtel (n 103) 8.

Queensland Health Victim Support Service (2019) identified the following instances where circles could be used on the ward: consumer morning meetings, staff meetings, staff handovers, case review, handling specific issues, discharges and farewell, family meetings, orientations and celebrations.¹¹¹ While these examples do not appear to be inherently restorative, embedding restorative dialogue into the meetings may result in a meeting that contains features of a restorative circle.

7C Patient who caused harm-patient harmed conference

Purpose and Features

The patient who caused harm-patient harmed conference is the first of four formal restorative justice conferences to be discussed in this report. Typically, a restorative conference is a structured meeting between victims, offenders and a restorative justice convener (with an option of a support person) with the aim of addressing an incident of harm. A patient who caused harm-patient harmed conference in a forensic mental health setting would bring together two patients following an incident that has taken place on the ward. A RJ conference may be particularly useful for patients that have been deemed to be ‘incompatible’ following an incident of violence on the ward.¹¹² Overcoming incompatibility may enable two patients who were previously unable to participate in the same activities or be present in the same common spaces, to restore a working relationship. However, as flagged in section 4E, RJ is not a ‘quick fix’ and should not be used with the aim of returning patients into spaces together where it is unsafe or counter-therapeutic.

1. Patient-patient conference case study : Jamie and Lisa

Background

Jamie and Lisa had been patients on the same medium security ward for several years. While Jamie and Lisa had known each other during this time, they had never developed a close relationship. Jamie held a position of power in the broader ward dynamics and seemed to derive pride from his persona as violent and unpredictable among other patients. Jamie was known to tell stories of violent run-ins with authority figures and was generally identified to be disliked or avoided by other patients. Lisa, who also had a

¹¹¹ Queensland Health Victim Support Service (n 25) 11.

¹¹² Power (n 32) 29.

history of violent offending, was identified by staff to be quiet, withdrawn and rarely engaged in any communal activities. It was known that Lisa enjoyed watching the television and could be regularly found in the common room at night. Staff members described Lisa as 'hard to get to know' and commented that they found it difficult to know what was going on inside Lisa's head.

Preparation

A restorative meeting took place between Lisa and Jamie following an incident of violence that had taken place on the ward 3 months previously, where Lisa assaulted Jamie following an incident in the common room one evening. While Lisa was identified to have initiated the violence, Jamie responded violently and both parties were forcibly separated by staff. Both parties were placed in seclusion as a result. The decision was made by Lisa's treating team to transfer Lisa to a high security ward, while Jamie remained on the medium security ward. This was seen as the most appropriate option, as Lisa and Jamie were now categorised as 'incompatible'. However, some staff felt uncomfortable at the institution's response. They felt Lisa's treatment and care did not require maximum security and that this move was a lazy option. Ultimately, the move was seen to be counter-productive to Lisa's recovery. Lisa had expressed remorse immediately following the violent outburst and was very distressed that this had resulted in her being transferred.

The idea of a restorative justice intervention was raised in a staff meeting. Each party was individually approached by a staff member to assess their interest in participating. Both Lisa and Jamie gave their consent, following a discussion about what a restorative justice conference would involve. The staff reiterated that the process was entirely voluntary and answered any questions Lisa and Jamie had about the intervention. It was decided that the conference would be facilitated by the ward psychologist, who had a pre-existing relationship with both participants and was a trained restorative justice facilitator. The meeting preparation was relatively short. After two preparatory individual meetings with the parties, it was evident that Jamie and Lisa were quite aligned. Both felt remorse at their actions. Senior personnel at the forensic institution were supportive of this intervention and the meeting took place 3 months after the incident.

Meeting

Following initial greetings, both parties described the incident from their own perspective. Lisa described how she had organised to be in the common room at a certain time that evening in order to watch the finale of her favourite show on television.

Lisa felt that since she rarely took up space in the common room and always 'kept to herself', she was entitled to watch this show. When Jamie entered the common room that night, 'showing off' and demanding that Lisa change the channel to a show that he preferred, Lisa described how she 'lost it'. Lisa described initiating the first blow, but was surprised at the force of Jamie's returned violence. Jamie stated that he had a reputation to uphold on the ward and refused to be made out to be a 'weakling' that gets 'beat up by girls'. Jamie stated that he wasn't aware that Lisa had organised her night around this show and confessed that he was just hoping to get a reaction from Lisa when he told her to switch channels. Both parties apologised and identified that the violence was context-specific, but that they did not have any long-term issues with one another to warrant them being deemed 'incompatible'. Lisa expressed feeling scared on the high security ward and deeply upset that her actions had led to this outcome. Lisa described being reclusive on her new ward and refusing to come out from her room for anything other than meals. After the conference, both parties returned to their respective wards, where they had access to a social worker, who was aware that they had participated in the restorative justice conference.

Review

In their feedback, both participants identified that the conference was a positive experience. They acknowledged that they had not considered what was 'going on' for the other patient and that their own violence was based on a reaction, rather than any deep-rooted issue towards the other person. Lisa was relieved that Jamie had accepted her apology. Jamie expressed sadness to hear that Lisa's behaviour had turned even more reclusive in her new environment and stated that he had no issue with her being transferred back to the medium secure ward. Staff members relayed this information and the outcome of the conference to senior personnel who reviewed Lisa and Jamie's 'incompatibility' status. Lisa was transferred back to the medium secure setting.

7D Patient who caused harm-staff harmed conference

Purpose and Features

Patient who caused harm-staff harmed restorative justice conferences have so far been the most common type of conference in forensic mental health settings.¹¹³ For example, Cook (2019) centres on three case studies all involving the assault of nursing staff by a

¹¹³ See Cook, Drennan & Callanan (n 16); Cook (n 15); Tapp et al (n 26).

patient on the ward. In this context, a restorative justice conference would respond to an incident of harm between a patient and staff member through a formalised intervention facilitated by a restorative justice convener. A patient who caused harm-staff harmed conference may be offered to supplement existing structures for staff support and patient treatment, with the dual aim of fostering staff wellbeing and patient recovery.¹¹⁴ The conference may have the effect of repairing the relationship, which in turn will improve the therapeutic functioning of the ward and the safety of staff and patients. This may be particularly important where patients and staff victims had a pre-existing relationship. Patients may have a desire to be forgiven and staff may wish to move on from the ward dynamics created by the dangerous or threatening behaviour.¹¹⁵

Referral process

It was found in the Brisbane model that there is no exhaustive list of how or where a referral may begin.¹¹⁶ However it is important that all participants are appropriately informed and that safety, suitability and risk are paramount considerations from the outset. Power (2016) identifies that this type of conference will be most suitable where there is a longer term relationship between the patient and staff member (for example, those that are found in medium or high secure services), rather than in an acute setting (where there is high turnover of staff and patients).¹¹⁷

Preparation

Preparatory work could be undertaken by either a facilitator who was not known to the parties, or by a facilitator who had an established relationship with the staff member and/or patient. This preparatory work could involve a short meeting with the facilitator where the ground rules and process are outlined, or could involve weeks of work with multiple meetings.¹¹⁸ Restorative language may be used throughout the preparatory work. It has been found that the process of preparation has value in its own right, even where the RJ intervention does not result in a conference.¹¹⁹ Refer to section 3D for discussion on the importance of supports for participants.

Practice Considerations

¹¹⁴ Cook (n 15) 877.

¹¹⁵ Cook, Drennan & Callanan (n 16) 517.

¹¹⁶ Queensland Health Victim Support Service (n 25) 11.

¹¹⁷ Power (n 18) 19.

¹¹⁸ Cook, Drennan & Callanan (n 16) 515.

¹¹⁹ Ibid 524.

Cook (2019) identifies that a core principle of an RJ conference in this setting is that the staff member is always at the centre of the intervention.¹²⁰ Staff members of forensic mental health institutions play a crucial role in maintaining relational security,¹²¹ promoting healthy relationships and ensuring safety. Clearly, there are identifiable benefits in attempting to repair relationships where there has been an incident of violence between a patient and staff. A conference may facilitate the therapeutic functioning of the ward, or it may enable staff and patients that were previously incompatible to salvage a working relationship. There are also undoubtedly nuances in the dynamic between staff and patients, including inbuilt power dynamics and a culture of bravado (see Section 4A). There may also be a dynamic of fear or anger between the parties as a result of the harm. Refer to sections 3A, 3B and 3E for additional relevant practice considerations including capacity, comorbidity and when a restorative conference might not be appropriate.

¹²⁰ Ibid.

¹²¹ Department of Health (n 70) 877.

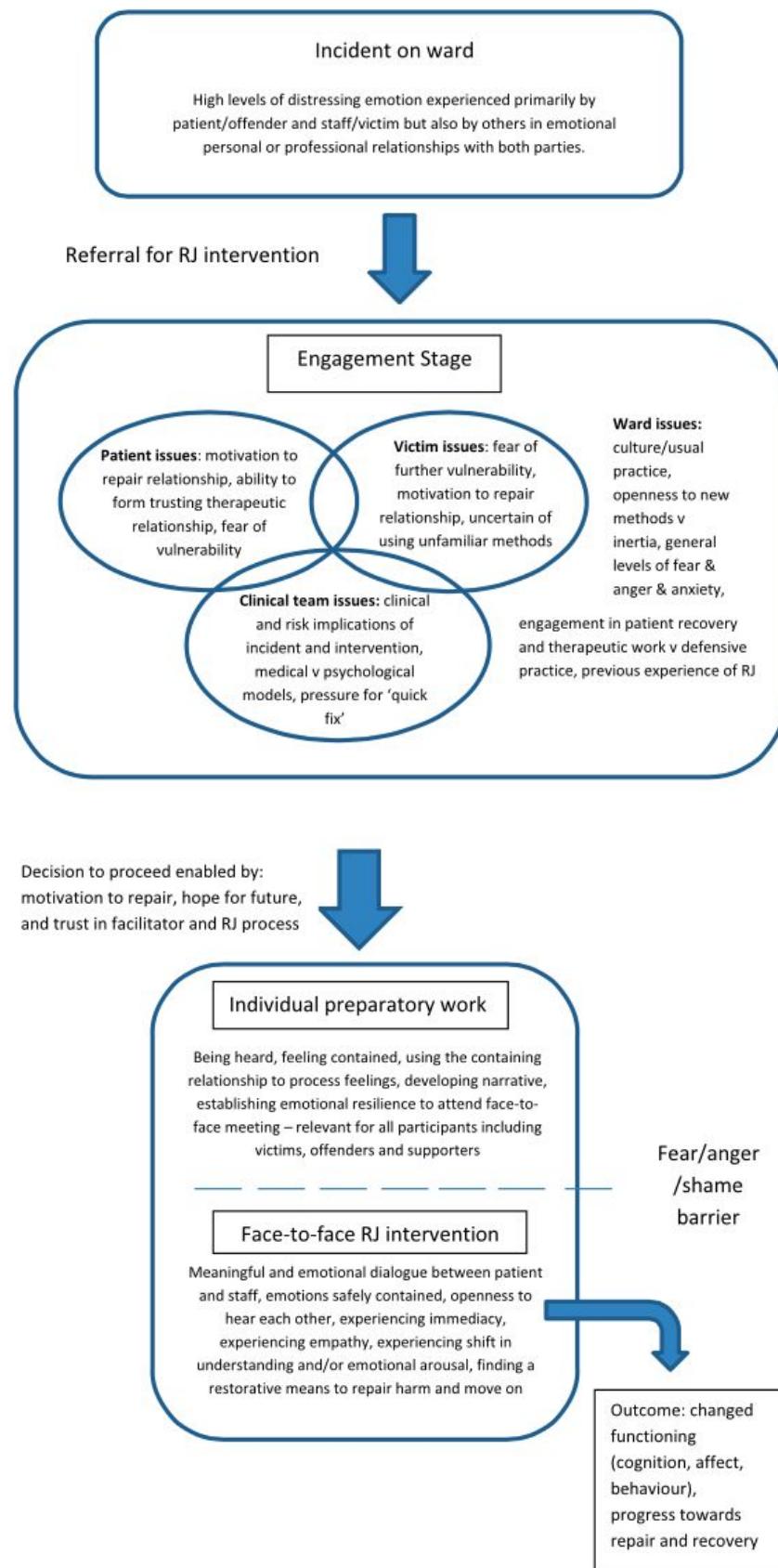


Figure 3: Cook, Drennan & Callanan (2015) Flow Chart

2. Patient-staff conference case study: *Sarah and Josephine*¹²²

Background

Sarah has been on the medium secure ward for several years and over this time, has developed relationships with the staff. Sarah is charismatic, playful and good-humored and is well-liked on the ward by both staff and other patients. However, Sarah is also spontaneously and unpredictable violent, usually when she feels unsafe or overwhelmed, as violence has always been Sarah's way of gaining control over situations that make her feel anxious. In these moments, Sarah's emotions are aroused and she responds by lashing out. Sarah has grown up in institutional settings from a very young age, with several years in both prison and inpatient mental health settings. During staff meetings about Sarah's treatment and care, Sarah's treating team are often split between those that feel she needs to be in a more secure environment, and those that feel she needs to be provided with an environment of emotional safety, holding hope that she will be able transition into a ward of lower security with time.

Preparation

The restorative meeting is between Sarah and Josephine, a nurse whom Sarah had assaulted on the ward, 10 months previously. Following the assault, Sarah was immediately placed in seclusion and transferred to a high security ward. Josephine and Sarah have not seen or had any contact with one another since the assault. Sarah and Josephine previously had a good relationship on the ward; Josephine was one of the staff that felt that Sarah should be treated with respect and care. Sarah expressed remorse very quickly after the assault and both parties responded positively to the idea of a restorative justice conference. It was decided that the conference would be co-facilitated by the ward psychologist (who had a pre-existing relationship with Sarah and was a trained restorative justice facilitator) and an external facilitator from a restorative justice service. The preparation for the conference was put on hold for some time as a result of Sarah's fluctuating mental health and Josephine was happy to accommodate this delay. During this time, the facilitators kept in contact with both parties to ensure that everyone was appropriately supported.

¹²² Case study adapted from Cook (n 15) 2-6, Toni and Sally.

When Sarah felt ready to recommence preparation, planning took place over several weeks, including multiple individual meetings with both parties. Josephine expressed to the facilitators how the assault had impacted her family and her work. Josephine discussed her professional boundaries and the level of vulnerability that she felt comfortable to disclose to Sarah. Josephine expressed concern that Sarah would perceive her as 'weak' or that being vulnerable with Sarah would expose her to the risk of more violence, but ultimately decided that Sarah was unlikely to have this reaction. Preparation with Sarah centred on preparing her to hear the impact of her actions on Josephine's life. Knowing Sarah's propensity to lash out when she felt emotionally vulnerable, the facilitators worked on building Sarah's emotional resilience and developing strategies to hear such information and cope with the emotional fallout. Preparation with both parties included laying out ground rules, what questions would be asked, who would support the parties, how the parties' greet each other, how the parties would indicate the need for a break, who would support Sarah back on the ward and what the consequences of an incomplete meeting would be.

Meeting

The meeting unfolded largely in accordance with the classic structure. Sarah and Josephine greeted each other, took their seats and had brief introductions before each party took turns describing the assault from their own perspective. Sarah described her thoughts and feelings prior to following Josephine down a corridor on the ward and hitting her in the head. Sarah described her relationship with Josephine prior to the assault as 'really good', stating that Josephine was one of the few staff members that she liked and trusted. In turn, Josephine described the impact of the assault on her, as well as the other staff members on the ward. She discussed the time she had to take from work and the additional anxiety that she now feels in her work as a result of the attack. For example, Josephine described how she felt constantly 'on edge' with other patients, which she felt compromised her ability to engage and connect with the patients. Sarah listened attentively and apologised for the impact of her harm. The second half of the meeting focused on repairing the harm and rebuilding trust. Both parties were hopeful that they could be on the same ward again at some time in the future. The conference wrapped up and Josephine returned a work and a peer support session that was organised to support her following the conference. Sarah returned to the ward, where she had access to a staff member, Sheryl, who Sarah liked and who had organised to be working that day in the event that Sarah needed additional support.

Review

Following up with both parties, Josephine reported that she was pleased that she participated in the conference and felt more comfortable to return to the ward where Sarah was, which she previously had not. Sarah was also pleased to have participated and to be given an opportunity to apologise face-to-face. Sarah felt sad and surprised to hear the extent of the impact of her actions on Josephine. She expressed remorse and recognised that Josephine had not done anything specific to elicit the violent reaction, but had merely been ‘in the wrong place at the wrong time’. The anxiety and vulnerability described by Josephine resonated strongly with Sarah, as Sarah identified these to be similar to feelings that she had growing up in institutional settings. Overall, the conference was deemed to be a success. Sadly, however, this was not the last time that Sarah was violent on the ward, and was eventually transferred long-term to a high security ward.

7E Family Group Conferences (FGC)

Purpose and Features

Family Group Conferences (FGC) have some overlap with restorative circles, but are directed specifically towards the patient and their family members (including, where relevant, significant individuals directly involved in the family). FGCs gained prominence in North America and New Zealand, primarily within the context of youth justice.¹²³ FGCs have an aim of helping to repair or rebuild fractured relationships between patients and their family members. Family members may be involved solely in their capacity as a family member of the patient, or they may also represent a victim of an offence committed by the patient. Even where family members are not victims of the index offence committed by the patient, they can often represent secondary victims, as they may experience grief and sorrow at the actions of their family member. Family members will have long-term histories with patients, which will be a relevant practice consideration. Additionally, Power (2016) describes instances where family members have ‘lost faith’ in mental health services, if their experience of obtaining mental health treatment for their family member has been unsuccessful in the past.¹²⁴

Practice Considerations

¹²³ Zehr (n 109).

¹²⁴ Power (n 18) 1.

It is important to acknowledge the many and varied nuances within family dynamics. There may be a long-term history of trauma and grief interwoven between family members. In this way, facilitators may need to be mindful about whether they are facilitating a conference in relation to historical family conflicts, or in relation to a specific instance of harm. This should be clear to all participants from the preparatory stage and ideally written into the ground rules.

7F Patient who caused harm-victim of index offence conference

Purpose and Features

A conference between a patient who caused harm and a victim of an index offence refers to a restorative justice conference between a patient and the victim of the offence that led to the patient being placed on a forensic order. It has been identified in the literature that these types of conferences involve a high degree of complexity,¹²⁵ and should be considered on a case-by-case basis.¹²⁶ At the time of writing this report, the writer could not identify an example of a conference of this type that had progressed beyond preparatory stages.¹²⁷ Cook, Drennan & Callanan (2016) in their study include five RJ interventions with ‘index offences’, including an offence of stalking, offending against own children, manslaughter of partner, violence against ex-partner and violence towards father.¹²⁸ Of the five interventions, two were in preparatory stages at the time of writing this report, two did not go ahead due to clinical mental health and risk factors, and one was halted due to concern about impact on the victim.¹²⁹ Cook, Drennan & Callanan (2016) identify the importance of continuing to examine restorative interventions with index offences.¹³⁰

Practice Considerations

There are specific practice considerations that arise in relation to patient who caused harm-victim of index offence conferences in the forensic mental health setting due to the inherent complexity of the setting. For example, it has been identified that a multi-disciplinary team should assess the suitability of the intervention, which includes

¹²⁵ Cook, Drennan & Callanan (n 16) 527.

¹²⁶ Ibid 513.

¹²⁷ Ibid 514.

¹²⁸ Ibid 516.

¹²⁹ Ibid.

¹³⁰ Ibid 527.

an assessment of the patient's capacity to consent and to meaningfully engage with the intervention¹³¹ (see section 3).

It was identified in Cook, Drennan & Callanan (2016) that there are many questions associated with RJ interventions that involve patients and victims of the index offence, such as 'who should make the first contact with the victim?'¹³² This question is not answered in their paper. It may be a professional from the patient's treating team, such as their social worker. However, it is important to consider the potential impact on a victim of a 'cold-call' contact from a forensic mental health professional. In some circumstances, a victim may be fully informed about the patient's whereabouts, their treatment, and their progress. Others may have chosen to take a more hands-off approach in relation to the patient who caused harm, in which case, an unannounced call from a forensic institution with an offer for a restorative intervention may be re-traumatising, triggering and unwanted.

As with all conferences, a patient who caused harm-victim of index offence conference should follow a clear structure, which adheres to agreed ground rules and may conclude with an outcome agreement, if that is found to be useful for the participants (although it is not necessary).¹³³ It is expected that preparatory work for these meetings will take numerous weeks due to their inherent complexity. A conference may begin and then be halted due to a change in a patient's mental health condition, to be re-initiated at a later date. As much as possible, victims should be supported to accommodate fluctuations in the patient's mental health and where possible (if all parties are still willing), to enable the restorative intervention to re-start when appropriate.

3. Patient who caused harm-victim of index offence conference case study: Eden, Sandra and John

Background

John has been on a medium secure ward for ten years. John was initially brought to the hospital following an incident of serious violence that led to the death of John's 60-year-old father, Phil. At this time, John was experiencing acute symptoms of psychosis, in combination with high rates of illicit drug use. The effects of John's

¹³¹ Ibid 513.

¹³² Ibid 526.

¹³³ Power (n 18) 19.

psychosis meant that John was having strong auditory hallucinations, in combination with a delusion that John was in danger from his father, Phil. As a result of this belief, John committed a serious assault against Phil, which resulted in Phil's death. Phil's two daughters, Eden and Sandra (John's sisters) were devastated by the death of their father and left feeling confused and traumatised by the actions of their brother. Eden and Sandra have not had any contact with John whilst he has been in the hospital, but has had updates on his treatment and progress from the hospital staff over the years. They hear that John has been doing well. John's treating team have informed Eden and Sandra that John has been taking his medication consistently, with only a few relapses and small instances of violence on the ward. They have also heard that John feels deep remorse for the actions that led to their father's death.

Preparation

The preparation stage for this restorative conference was lengthy. This time-frame recognises the highly complex nature of the intervention, the long-term relationships of the parties and the significant violence that had occurred. John had initially expressed a desire to see his sisters face-to-face and to apologise for the death of their father. He was aware that they were engaged in his treatment from afar and that they had been informed that he was doing well. He expressed his desire to Elizabeth, one of the ward social workers. Elizabeth and John had enjoyed a long-term relationship over John's many years on the ward. John asked Elizabeth what she thought about him making contact with Eden and Sandra and how he could go about it. Elizabeth, who had recently participated in a restorative justice training seminar, informed John about restorative justice. Elizabeth was mindful to be clear with John that this type of conference had not yet taken place at the hospital and was careful to manage John's expectations. She explained that the process is voluntary for all participants and that even if his sisters' consented, it would involve a great deal of preparation and planning. John stated that he felt emotionally resilient at the stage of his recovery and felt a desire to reach out. Even if they did not wish to participate at that time, John wanted them to know that the option was there.

Elizabeth raised John's wishes in the next staff meeting with John's treating team, who had also participated in the restorative justice training seminar. There was general receptiveness to the idea, and many staff members commented on John's progress and the potentially rehabilitative impacts that a conference may have for John. It was discussed that any process would need to be carefully planned, and that any conference would need to include an external facilitator with expertise on restorative justice conferencing. As a first hurdle however, the staff discussed how to reach out to

the sisters and whether or not this was appropriate. One staff member stated that she had been in semi-regular contact with Eden and Sandra over the years and felt that she had developed a good working relationship with them. It was decided that this staff member would float the idea with Eden and Sandra. If they seemed receptive, the staff member would formally ask if they would like to participate in a restorative justice conference with John.

Following the initial contact, it was found that Eden and Sandra were surprised but pleased that John had expressed a desire to meet with them. Eden and Sandra were given information about restorative justice conferences and how they operate. They gave their formal consent to participate in the process. An external and internal facilitator began preparation with all parties, which included several individual meetings over multiple weeks. A conference structure was written out, including ground rules and a script of the information that each party wanted to convey to the other. John expressed a desire to write a letter to his sisters before the conference, which was written and passed along to Eden and Sandra through the facilitators. It was decided that Elizabeth, the social worker, would also attend the meeting as John's support person. Sandra and Eden decided that they would not bring additional support persons, but act as each other's support person.

Meeting

The restorative meeting was emotionally-charged from the outset. John had not seen Eden and Sandra in over ten years and all parties were emotional upon initial greeting. John hugged both of his sisters; all three participants were crying. The conference did not deviate significantly from the overall structure. After greetings were finished, John described his experience of the assault perpetrated against their father as he remembered it. John recognised that due to the intoxication and the experience of the psychosis, there were parts that he did not completely remember. John described the auditory hallucinations and the words that he was hearing in his head, which were telling him that he was in danger and encouraging him to commit violence against their father. Eden and Sandra listened attentively, both were silently crying. Eden and Sandra individually described the impact of John's actions on their personal lives, including the devastating impact the death had on their mother. They expressed sadness that none of their children will ever meet their grandfather. At this, John also began to cry. John profusely apologised to Eden and Sandra and expressed deep remorse for his actions. Eden and Sandra both accepted his apology.

Following the apology, the meeting had a lighter tone. All participants appeared visibly relieved to have overcome that part of the meeting and to be moving towards redress and restoration of the relationships. Eden and Sandra apologised for failing to come and visit John in all these years, and thanked him for initiating the first step on their journey towards reparation. John thanked Elizabeth for informing him about restorative justice. Sandra asked John if he would like them to come and visit him in the future, to which John was visibly happy and confirmed that he would. Eden told John that this was the ‘best’ that she had ever seen him and asked him if he would promise to continue taking his medication, as it appeared to have positive effects on him. John agreed.

Review

After the meeting, Eden and Sandra both went home to their respective families, who were all aware that the restorative conference had taken place and were able to provide support. John and Elizabeth had pre-organised a debriefing meeting before John returned to the ward. Eden and Sandra both individually commented that it was helpful for them to understand what had gone on in John’s head at the time of the assault. They realised that John’s actions weren’t motivated by malicious intentions; they hadn’t previously understood that John genuinely felt and believed that he was in danger. Hearing John describe what the voices said to him in these moments made Eden and Sandra comment that it was as if John was acting upon the words of another. John told Elizabeth that he felt a significant weight off his chest, even immediately after the conference. He hadn’t released how important it was for him to apologise to his sisters, describing it as a ‘release’ when they accepted his apology.

8 Summary of findings

There are a number of considerations when thinking about implementing restorative justice in forensic mental health settings. Attention must be given to the nuanced practice elements, as well as the specific risks and challenges that arise in application of RJ in this setting. An examination of the diverse range of options that are available for implementation will also be necessary, to ensure that the restorative approach chosen is appropriate for the context of the harm. Ultimately, any necessary decision-making regarding RJ implementation broadly, or applicability to an individual case, will be done by the institution, in accordance with procedures and processes to ensure the safety of patients, staff and the community. This report identifies institutional resistance to restorative justice and the cultural shift required across all levels of staff to be significant

challenges to implementation. The literature suggests that staff may be reluctant to step out of their professional role and assume a position of vulnerability for fear of being perceived as ‘weak’. Institutional support and the championing of the process is crucial for the success of a RJ program in this setting. Additionally, it is important that the forensic institution adopts a healthy relationship with risk when considering a patient’s appropriateness for a restorative intervention, to avoid custodial thinking and anti-therapeutic outcomes for the patient.

This report suggests embedding restorative justice into a forensic institution in a steady, but assured manner. This may involve starting out with training of a handful of staff members, who are then able to answer questions and inform others about core RJ principles. Staff may feel most comfortable with first embedding restorative language into their interactions with patients, before beginning to identify situations of conflict between patient-patient or patient-staff that may benefit from a restorative justice conference. Given their complexity, conferences involving victims of the index offence require the deepest consideration. This report recommends that other restorative justice options are implemented first in the forensic institution, with an eye towards patient who cause harm-victim of index offence conferences for when the institution is culturally-fertile. Both domestically and internationally, such conferences have been the least-explored restorative option, although all literature identifies the potential for significant benefit to both the patient and the victim of the index offence. Training, preparation and institutional support will be key ingredients to a successful patient who caused harm-victim of index offence conference.

Given the strong theoretical compatibility between restorative justice principles and principles of treatment, rehabilitation and recovery that are central in therapeutic settings, the slow development of RJ in this space is curious. To date, people with serious mental illness have been excluded from restorative justice interventions on the basis that they do not have capacity to participate. This report asserts that this assumption is not only unsubstantiated by evidence, but it contravenes core principles of the *Convention on the Rights of Persons with Disabilities*, such as participation, agency and access to justice. Within Australia, the writer of this report has only been able to identify one RJ program currently being implemented in forensic mental health settings in Brisbane and a few programs operating internationally. While restorative justice in this space is clearly new, momentum seems to be gathering. A real opportunity has been presented to Forensicare, Victoria’s leading mental health provider, to be a leader in this space.

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