International innovations in restorative justice in mental health – next steps for Australia

Michael Power – Churchill Fellowship 2017
I would like to acknowledge the support of the Dorothy and Brian Wilson Churchill Fellowship to research innovations for improving the lives of victims of serious violence committed by people with a mental illness - USA, Canada, UK, The Netherlands
What is Restorative Justice (approach)?

- Restorative conversations
- Victim Offender Dialogue (mediation)
  - Communication by letter
  - Via a 3rd party (facilitator / surrogate victim)
  - Face to face meeting
- Circles (can be one occasion or ongoing)
How do restorative approaches fit with the harm caused by people with a serious mental illness?
Arguments against the use of restorative approaches in cases where harm is the result of actions by a person with a serious mental illness?
Arguments for the use of restorative approaches in cases where harm is the result of actions by a person with a serious mental illness?
Dr Sergio Santana (psychiatrist) Medical Director, Forensic Assessment and Outpatient Services

A secure forensic mental health service which uses a restorative approach and family therapy with

- family members of forensic patients
- non-related victims of forensic patients
- in cases of serious violence where the person charged is found not criminally responsible
• Multidisciplinary team that:
  • actively reaches out to family members and unrelated victims
  • provides extensive psychoeducation to all involved
  • seeks forensic patients’ consent to share information with family members and unrelated victims
  • facilitates communication with victims on the patient’s mental illness, care, treatment and ongoing risk management and rebuilds relationships where possible
  • long timeframes as patients become unwell and readiness of victims for communication about patients
  • enables unrelated victims to move on after sharing of information
United States

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Judge Alex Calebrese, Red Hook Community Justice Center (Centre for Court Innovation) New York - offers a range of services for people committing offences, and victims in the one court covering criminal law, civil law (tenancy) and family law

Offers restorative circles as one option to respond to lower level charges of violence (1 year or less in prison)

Restorative Circle can involve people with a mental illness – but they first need to receive treatment and then return to restorative circle process
Other options - US

Dr Thomas Hafemeister (retired Professor of Law and Psychology) Charlottesville

- makes more sense to offer restorative justice for people with a mental illness pre charge, or pre court hearing – for lower level violence cases
- aim to keep people with a mental illness out of the justice system
- detailed model provided – circles not suitable for people with serious mental illness who are already suspicious of professionals and difficulty processing information from multiple people in the room
- logistical problems in offering Restorative Justice post court (some years after the offence – less motivation for victims)
- usually secure forensic mental health services located away from victims and therefore burden on victims to travel
- logistics in undertaking preparation with victims and patients – significant travel involved
Role of the media

Bob Koehler, syndicated journalist, with the Chicago Tribune

- trained restorative justice facilitator and uses peace circles in his community to respond to incidents of violence
- role of peace journalism in promoting understanding of the role of restorative justice and peacemaking
- promotion of positive stories about the use of restorative justice in different contexts
RJ in forensic mental health
The Firs, Sussex NHS

- Restorative Justice (RJ) commenced being implemented by Dr Gerard Drennan (psychologist) in 2012 – medium secure forensic mental health service (men and women).
- Lead now for RJ – Dr Andy Cook (psychologist).
- Use of RJ with
  - Patient to patient violence
  - Patient to staff violence

The Firs, Sussex NHS

Implementation

• Trained a cross section of professional staff in RJ
• Used an external trainer and RJ facilitator for ongoing support and co-facilitation of RJ meetings (Henry Kiernan)
• Primarily used for patient to staff violence
• More detailed preparation and external and internal facilitators required when more significant violence
• Aim to expand to victims of offences by forensic patients
The Firs, Sussex NHS

Lessons learnt

• Challenge to maintain with staff changes
• Compliments and adds something extra to work with patients
• Need to embed RJ across multiple areas – dealing with harm caused is part of core business in working with forensic patients
• Start small first to build momentum and experience
• Process can be used shortly after violence in a mental health ward in lower level cases of violence with less preparation
• Next step to expand to victims of forensic patients in the community – partnership with RJ services
• Recognised for nurses (and other staff) that RJ means they step out of their role to talk about the impact of violence
• Renewed energy and emphasis
Tarentfort, Allington & Brookfield Centre
Kent and Medway NHS
Implementation

Use of RJ to respond to violence between forensic patients and to staff (forensic patients have mild to moderate intellectual disability and mental health diagnosis) – low secure

• Jan – June 2016 there were 220 harmful events to staff and patients (59 patients and 166 staff)

• External RJ facilitator (Henry Kiernan) provided training and ongoing facilitation of peer supervision from November 2016 (pre and post evaluation of improved understanding and confidence in using Restorative Conversations)

• Lead Sarah Cooper (psychologist)

• Established RJ Practice team (reviews referrals and allocates cases)
  • RJ Facilitators
  • RJ Champions on the wards
  • RJ Representatives (suggest use of RJ in case review meetings)
Kent & Medway NHS

Lessons Learnt

• Started with Restorative Conversations
• Need to assess capacity of patients to manage a joint meeting
• Cultural change through extensive promotion within wards
• RJ linked to
  • values of the service (Respect)
  • Establishing Restorative wards
• Education afternoons on Restorative Conversations
• Referrals for RJ from the treating team to the Restorative Practice team
Broadmoor, West London Mental Health

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Implementation

• External RJ training of a cross section of staff, OT, consultant psychiatrist, psychologist, social workers, security staff, practice nurses, nurse consultants, health care assistants

• Lead for RJ – Dr Estelle Moore (psychologist)

• Referrals over the last 2 years

• External RJ peer supervision (Henry Kiernan)

• Focus on
  • ‘incompatible’ patients who needed to be in the same location
  • patients who had harmed staff
  • patients who wish to re-establish relationships with family
Lessons Learnt

• Maybe best to start conversations with patients about the impact of harm

• Assessing patients who are not suitable (those with empathy deficits - Dr Simon Baron Cohen – autism and psychopathy - those who have difficulty mentalising / those who can perceive empathy, but not show it, and those who may wish to dominate others)

• Determine who decides if someone is not suitable for RJ

• Adapt the way RJ used with serious mental illness – for example, use of letters
Bethlam Royal Hospital  
South London & Maudsley NHS

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Implementation

- Lead Dr Gerard Drennan - recognised benefits of RJ to contribute to desistance of future offending
- River House (medium secure) and Chaffinch (low secure) staff not in a position to take on implementation of RJ
- Decided to trial the use of Sycamore Tree program with some adaptations from prison environment (in 42 UK prisons and 34 countries)
- Delivered in collaboration with Prison Fellowship (Fin Wood, RJ and Sycamore Tree facilitator)
- Program uses offending behaviour group-work program with surrogate victim input – 6 x 2.5 hour sessions
South London & Maudsley NHS

Lessons Learnt

• 3 programs run so far – high level of group attendance – 96% to 100% attendance

• Awaiting evaluation (included 4 outcome measures and qualitative component)

• Challenge to adapt the program to fit with forensic patients

• Could be adapted further for female population and people with an intellectual disability

• Could develop specific outcome measure for forensic patients

• Issue of faith based component

• Future programs – in collaboration, or new program
The Netherlands

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RJ in forensic mental health

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The Netherlands

- Staff at the Mesdag Clinic were funded for a literature review of contact between victims and mentally ill offenders.
- In 2016 they developed a guideline in collaboration with the Van Der Hoeven Clinic titled `Contact between victims and mentally ill offenders’.
- Collaborative process used by staff of the two clinics with forensic mental health services, Dutch Victim Support, Restorative Justice Foundation and other victim support services.
The Netherlands
• Implementation commenced in May 2017
• Evaluation from May 2017 to September 2018 across four forensic mental health services
• Guideline provides detailed scenarios and information for social workers in managing different referral pathways for RJ
• Services involved:
  • Van Der Hoeven Clinic, Utrecht
  • Mesdag Clinic, Grongingen
  • Pompe Clinic, Nijmegen
  • De Woenelse Poort Clinic, Eindhoven
  • Restorative Justice Foundation, Dutch Victim Support and other victim support services
The Netherlands

Oostvaarder Clinic (Almere) has commenced restorative justice conferences between victims and forensic patients

Lessons Learnt

- Process of restorative justice has been an extension of work by social workers to reach out to victims to provide them with information on forensic mental health system
- Social Work role identified as the role to lead the Restorative Justice process
- Work with victims and restorative process has provided additional perspective for treating teams to consider as part of their treatment, often can overlook impact of the violence due to long term treatment role
Culture shift – possibility of RJ

- Offender has a **psychiatric illness**
- Offender does **not have empathy or regret** toward the victim
- The victim is **vengeful** toward the offender

Therefore is contact between the patient and victim possible?

- In some cases it is not, in some cases it is
- Crucial to inform the victim and offender about each others possibilities and limitations
- Victim-Offender-Contact is more likely in the case of family ties, but can be used between non relative victims and patients
Australia

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Restorative Justice in forensic mental health is not offered in Australia.

Options for Australia:

**Restorative Conversations** on their own in mental health services (low, medium and high secure)

**Pre charge, or Pre Court Hearing** – facilitated RJ process requires a significant change to the current criminal justice system and involvement of Police as well as widespread community support. For example, build on the Victorian Community Justice Centre (Community Conferencing Program).

**Post Court** – in forensic mental health services when a person is found of unsound mind (or equivalent) and starts getting well.
Post Court – restorative justice model in forensic mental health

- Tiered implementation (restorative conversations, facilitated RJ process (individual meetings leading to communication through a letter / 3rd party communication, or joint meeting)
- Start with violence between patients and patients to staff and then extend to victims of criminal offences
- Need to include external Restorative Justice facilitators for victims of criminal offences and other situations
- Internal Restorative Justice Facilitators (trained mental health staff) can be used for patient to patient violence, or patient to staff violence
- Process needs to be voluntary for both patients, staff and other victims
- Significant work is needed to embed RJ model in the Forensic Mental Health Service
Australia

Post Court – restorative justice model in forensic mental health

• Experience has shown the process will usually be patient initiated, but then victim led
• Approaches to victims to offer RJ needs to be from a 3rd party (from a victim support service and not a forensic mental health service)
• Assessment of suitability of patients – needs to be supported by the treating team
• 3 to 4 individual sessions expected prior to a joint meeting
• Reaching an agreement is not primarily the aim for face to face meetings
Post Court – restorative justice model in forensic mental health
Model needs to include:

- Documented intended benefits for patients and victims
- RJ process to be used, by whom, when and why
- Referral process and criteria
- Establishment of RJ practice team
- RJ peer supervision
- What is recorded in staff and patient files
- When sessions are facilitated by an external RJ facilitator / or internal RJ facilitator, or both
- Post RJ session follow up for the victim and the patient
Post Court – restorative justice model in mental health

Overarching Implementation:

- Senior leadership support and RJ practice team
- To be located in a medium to longer term treatment service where there is an investment in relationships (less suitable in acute short term care units)
- Extensive training and peer supervision across multiple professions in mental health
- Examples promoted on positive use of RJ across the service and organisation (media stories)
- Embed RJ in education, training days, Champions in the mental health service
- To be viewed as contributing to core business of responding effectively to violence and reducing further violence
- Partnership with victim services to promote the use of RJ and restorative justice providers involved in implementation
Australia

What’s next

• Maintain professional network of restorative approaches in mental health with UK, The Netherlands and US
• Develop a detailed model for trial in an Australian state / territory
• Develop and fund research / evaluation of a trial of RJ with suitable process and outcome measures
• Secure funding for the trial, that includes collaborative development of a localised model, training, facilitation (external), peer supervision and travel costs
• Develop organisational policy that defines referral pathways, assessment of suitability, what is recoded and where, eligibility criteria, (refined over time)
• Long term monitoring of key outcomes (satisfaction with the process / support for recovery / integration of impact of harm to influence reduction in future offending)
Questions

“Success is not final, failure is not fatal: it is the courage to continue that counts.”

Winston S. Churchill
Sources

- National Community and Restorative Justice Conference – Oakland, California
- 3 days with Dr Sergio Santana and MDT, Calgary (case conferences, family therapy sessions and case reviews)
- Restorative Justice Forum 19 July 2017 (London), including presentations from four forensic mental health services – (Dr Estelle Moore, Dr Andy Cook, Dr Gerard Drennan, Sarah Cooper, Fin Wood and Henry Kiernan - RJ facilitators)
- RJ peer supervision meetings at Kent and Medway (Dartford) and West London (Broadmoor) and protocol documents
- Other meetings with
  - Professor Marilyn Armour (University of Texas)
  - Bob Koehler, syndicated journalist (Chicago Tribune) editor, teacher (Illinois)
  - Dr Thomas Hafemeister (Charlottesville)
  - Dr Gerard Drennan (South London and Maudsley NHS) & Fin Wood (RJ Facilitator ), Henry Kiernan (RJ Facilitator), Remedi RJ services England
  - Red Hook Community Justice Center (Judge Alex Calabrese and staff - NYC)
  - Multiple staff at the FIRS, Sussex
  - Staff at three forensic mental health services in The Netherlands (Oostvaarders, Veldzicht, Van Der Hoeven)
  - Dutch Victim Support (Slachtofferhulp Nederland), Utrecht