

Restorative Justice and Mental Illness: Combating the ‘Spider Syndrome’

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF

MASTER OF SOCIAL WORK

in

The Faculty of Graduate and Postdoctoral Studies

(Social Work)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

January 2014

Abstract

This study explores the experiences and perspectives of three restorative justice (RJ) practitioners who processed cases involving service users with serious and persistent mental illness. Participants were recruited in the United Kingdom with the help of restorative justice contacts in London, England. The three practitioners who came forward took part in one semi-structured interview that lasted approximately one hour. A descriptive framework was used and emerging themes were coded. Research findings show that personal contact along with mental health education appeared to increase participants' willingness to process RJ cases with service users who have serious and persistent mental illness, due to a subsequent reduction in stigmatizing thoughts and behaviours. The latter are components of what one of the participants referred to as the "Spider Syndrome": fears and misconceptions that occur due to a lack of knowledge and understanding. This, along with participants' own recommendations, suggests that mental health training which focuses specifically on skills and raising awareness, in combination with increased exposure to individuals who have serious mental illness, could be an important contributor to enhancing practitioner skill and increasing the use of RJ with such service users. Findings also suggest that restorative justice can be used as a stigma-reducing tool, both at the practitioner and service user level. These insights may hold important implications for social work, mental health and development of practice in the field of restorative justice.

Preface

This thesis is an original intellectual product of the author, Ania Dwornik. The fieldwork presented in the findings and conclusion was collected and analyzed by myself, the author, with the approval of the UBC Behavioural Research Ethics Board (# H12-03327). I conducted this work independently, under the supervision of my faculty supervisor and Principal Investigator, Dr. Frank Tester, as well as the other members of my advisory committee: Dr. Stephanie Bryson and Dr. Simon Davis.

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Acknowledgements

I would like to acknowledge the members of my advisory committee: Frank Tester, Stephanie Bryson and Simon Davis. Thank you for agreeing to take my project on, and for always making yourselves available despite busy schedules and massive workloads.

Thank you also to my friends and colleagues at UBC and in London, with special thanks to my “thesis crew”. Without your ears to vent and debrief to I would not have made it.

Thank you also to the members and friends of Stepping Stone Community Service Society, who inspired me to do this work in the first place.

Last but not least, to Mom and Chris. Thanks for putting up with my stress over the past two years.

To my mom, who has been my rock, and without whose moral, financial, and emotional support I would never have been able to pursue any of my post-secondary endeavors.

Reflexivity

I wanted to take a few moments to discuss my reasoning behind this choice of topic. While tracing back my motivation for this research I came to learn that it has many branches. During my Foundation year I did my practicum placement on the mental health team of the Correctional Service of Canada (CSC). At the time, I was also involved in restorative justice work in Vancouver. While at the CSC, I found that I had the desire to merge these two areas of my interest.

I went into my placement one day and began to inquire into restorative justice programming within the CSC, with a special focus on offenders with mental illness. Since this was the population that I had been working with it seemed a natural line of inquiry to pursue. I was given information on all the restorative justice initiatives within the CSC, and directed to a broader body of community resources; however when I asked if any of these programs worked specifically with offenders with mental illness I was greeted with a blank stare. "Well no, they can't do it", I was told.

I suppose I must divulge more about my personal history in order to fully communicate the effect that this response had on me. Prior to making the decision to go back to school and pursue an MSW I had been working in a community mental health centre. I worked as Community Support Worker out of a mental health clubhouse in the Fraser Valley. I loved this job. The place was wonderful, the work rewarding and the staff amazing; however what I loved most about the job was the community and the people in it, the so called *clients*. Having an undergraduate degree in psychology I had always been interested in mental illness, but through a much more medical and expert-driven lens. Even previous employment positions followed this general model and reinforced my belief

in such a worldview. It wasn't until I began to work in the clubhouse and infiltrate that community that I learned about how naïve and uneducated I had truly been. It was a humbling experience as I began to learn about how little I knew. I suddenly witnessed strong and inspirational individuals with serious mental illnesses who maintained a rewarding quality of life. They worked, they volunteered, they dated, and they drove. They maintained relationships and raised children. They found joy in life in things that I took for granted. I gained an overwhelming respect for these individuals and began to see how strong they were rather than how weak. They struggled constantly and were often brought down by their illness, but always fought to regain control and come back. This was also when I first learned to truly appreciate the psychosocial rehabilitation model and began believing in recovery. My work in this community, which accepted me with arms wide open, truly altered my perspective and had a profound impact on my practice. I began to value strengths-based and client-centered approaches, and felt grateful for having been put in my place.

Going back to my experience at the CSC, you can see how the answer to my question did not sit well with me. I did not say much in response at the time but went home and reflected. I thought about clients with whom I had worked in my job and conversations that I had had with them. I recounted numerous occasions where they had shared stories with me about their manic or psychotic episodes, and the feelings of guilt and shame that often accompanied them. They readily articulated emotions, experiences and empathy, and recognized the impact their actions had had on others. They recollected their stories in a temporal order that was easy to understand. Faces of my clients flashed before my eyes. "What do you mean they can't do it?" I thought. Sure they can.

It was this moment that inspired me to do something, though I still did not know what. As I studied restorative justice and its critiques more thoroughly, my wealth of information on the topic grew and I soon discovered that the individuals I spoke with at the CSC were not alone with these preconceived assumptions about people with mental illness. A thorough search of the literature revealed that articles studying the use of restorative justice amongst this population were nonexistent. As I searched farther I discovered that the Canadian Mental Health Commission (2012) had outlined diversion through restorative justice as a possible method of diminishing the overrepresentation of individuals with mental illness in the criminal justice system. How is it, then, that so little appears to have been done?

I contacted the restorative justice department at the CSC recently through e-mail and asked again about programs that worked specifically with this population in Canada. Again I was told that none existed as far as they knew. Since the overrepresentation of individuals with mental illness is a real issue in Canadian prisons, and restorative justice has been identified as one possible solution, what is hindering the expansion of RJ programming with this population? This, along with a desire to advocate for individuals with mental illness has become the main driving force behind my pursuit of this work.

Introduction

Restorative justice and mental health are two highly compatible fields of social work practice. I will construct this argument by exploring mental health, restorative justice and social work practice and discuss the components that make up the backbone for this research. I will begin by discussing the core principles of restorative justice, before moving on to a discussion about mental illness. I will briefly describe the history of mental illness in Western culture, with special attention to how changing social norms and values influenced definitions of normal and abnormal behaviour. Following this I will discuss the biomedical model, briefly touching on some of the evidence for neurochemical explanations for mental illness. In this I will provide succinct descriptions of thought disorders, mood disorders and personality disorders, paying special focus to illnesses that are most prevalent.

I will then provide an alternative approach to mental illness: one that views abnormal behaviour as a social construction, although I will present evidence in support of the argument that these two approaches need not be mutually exclusive. I will then discuss the concept of psychosocial rehabilitation and the recovery model. This will be followed by a discussion on stigma and its impact on people living with mental illness. I will end my literature review with a discussion about restorative justice, social work and mental health, highlighting the similarities between these fields, using the context of the literature to pave the way for my research question. I will then discuss the study itself, highlighting some of the challenges of conducting research on this topic, as well the providing support for the notion that this is in fact, a relatively new and unexplored area of research, if not of restorative justice practice. I will then present my findings before ending with a detailed

discussion about how they relate to the literature, and what implications for restorative justice and social work practice they may yield.

Literature review

What is Restorative Justice?

Restorative justice (RJ) is an alternative approach to the punitive model of judicial litigation. It is both a philosophy and a set of models and procedures for working with victims, offenders and communities impacted by crime. RJ aims to employ alternative methods of administering criminal justice that are more holistic and sensitive to the waves of impact that a criminal act has on those affected. These methods include, but are not limited to, victim-offender mediation, family conferencing, community accountability boards, and sentencing circles (Correctional Service of Canada (CSC), 2012; O'Brien, 2007). It is widely accepted that the first case to be processed in Canada using an RJ model occurred in Elmira, Ontario in 1974 (Zehr, 2008). It was used as an alternative method of dealing with a case involving property offences, under the pretext of the Victim Offender Reconciliation Program. Zehr (2008) argues that this case was so successful that it inspired a movement and launched the present restorative justice framework. Today, although many different models of RJ are practiced victim offender mediation remains the most frequently used in the United States and Europe (Zehr, 2008).

Restorative justice has its roots in Aboriginal practices as well as Mennonite conflict resolution strategies (Van Wormer, 2004). It is not a new concept, though it has seen a recent re-emergence since the 1990s brought on by critics of the current punitive model (Morris, 2002; O'Brien, 2007; Wenzel, Okimoto, Feather, & Platow, 2008). Restorative justice is a paradigm that takes crime out of the hands of judicial litigators and places it back in the hands of those it rightfully belongs to: those most affected. It sees crime not as

an infraction on State law but rather as a rupture in relationships, and is founded on the notion that it is through rebuilding these relationships that emotional restitution, restoration and healing can begin (CSC, 2012; Wenzel et al., 2008). RJ is about repairing harm not about obtaining vengeance (Van Wormer, 2004; Wenzel et al., 2008).

Furthermore it acknowledges that a criminal act impacts more than just the offender and the victim. Consequently it also gives voice to the community (CSC, 2012; O'Brien, 2007; Van Wormer, 2004). RJ incorporates a needs-based approach to healing and recognizes that incarceration is not the answer.

RJ ideology is based on three core principles: to repair harm, to reduce risk and to empower community (O'Brien, 2007). Zehr (2008) argues that restorative justice is also grounded in three basic assumptions: "1) crime is a violation of people and relationships, 2) violations create obligations, and 3) the central obligation is to put right the wrongs" (p.4). The paradigm also recognizes that although the victim may be most affected by the crime, there are often numerous stakeholders whose interests should be considered. Consequently RJ recognizes the victim, the offender, as well as the community, all of whom are given equal voice (CSC, 2012; O'Brien, 2007). This approach "condemns the act but not the actor" (Van Wormer, 2004, p.107) and is victim-led, making victim empowerment a key component of any RJ process. Victims are supported so that they can transform from 'victim' to 'survivor' and are consequently at the forefront of any RJ undertaking (Sullivan & Tift, 2005). On the other hand, the offender is given the opportunity to take ownership of his or her actions, accept accountability, apologize and begin to make amends for the hurt that he or she inflicted (CSC, 2012; Sullivan & Tift, 2005; Wenzel et al., 2008). It is not an easy sort of criminal justice. In fact, one could argue that RJ is the true expression of being

tough on crime. Alternatively, RJ has also been referred to as the peacemaking, conflict-resolution (Zehr, 2008) or restorative approach to justice (Restorative Justice Council (RJC), 2012) as a means of highlighting its emphasis on healing and resolution.

Few could hold more legitimacy when speaking about RJ's success than those who have been through it. Daniel Johnson (2008), an offender serving a lengthy sentence in a Texas prison for sexual assault wrote an article detailing his experience with RJ. He writes: "The dialogue that occurred between my victim and me was....that missing component in my own personal regeneration that, for me, could not have been fulfilled in any other way" (p.90). It is perhaps as a result of success stories like these that RJ moved outside of the criminal justice system and begun to infiltrate a wider range of areas, including schools, churches, care homes, neighbourhoods, and workplaces as a successful conflict resolution technique (RJC, 2012; Wenzel et al., 2008; Zehr, 2008). The potential for its use appears extensive.

Restorative Justice and the UK

The United Kingdom (UK) has recently demonstrated increased interest in RJ within the context of its criminal justice system. In the autumn of 2012, a decision was made in the House of Lords to amend the *Crime and Courts Bill*, introducing restorative justice legislation for adult offenders (RJC, 2012). This was done following a consultation process, in which politicians, think tanks and interested parties were able to give contributions. A document containing documentation of said consultations, titled "*Punishment and Reform: Effective Community Sentences*", was published the same day (RJC, 2012). An online petition recruiting public support for such endeavors had also contributed to the promotion of this movement.

The main guiding force behind this new legislation was an acknowledgement that the criminal justice system had been too focused on offenders, and insufficiently on victims (RJC, 2012). The restorative justice legislation was consequently a response to this deficiency, and inspired by victim's voices. As such, legislation implementers and supporters defined RJ as a severe sort of justice, where offenders were made to face the consequences of their actions and held accountable in the face of their victims (RJC, 2012). As a component of the criminal justice system, one could assess that this approach remained within the confines of a retributive model, with specific emphasis on victims' rights. Wenzel et al. (2008) note that the Western criminal justice system is deeply entrenched with the notion of punishment. The belief that punishment of the offender is the only way to uphold or rebuild justice is central to a Western way of thinking about criminal justice. Consequently, it is not surprising that creators of this new legislation placed it within the context of a punitive worldview, with emphasis on offender accountability.

The Restorative Justice Council, a non-profit advocacy group that played an instrumental role in the creation of the new legislation, was empowered with taking the lead on the implementation on this new legislation, in close partnership with the Ministry of Justice. It is presently moving toward standardization of practice, accreditation and promotion of best-practice methods (RJC, 2013). It has developed a set of best-practice guidelines for practitioners, and offers a practitioner and trainer registry. It also continues to be involved in RJ research and communication with the public on matters relating to RJ.

The RJC claims that this new legislation is the "biggest development for restorative justice in England and Wales since legislation introducing referral order panels to the

youth justice system in 1999” (RJC, “*Legislation Introducing Restorative Justice for Victims of Adult Offenders Announced*”, 2012). This present legislation initiates RJ at the pre-sentencing stage, attempting to offer services at the earliest stage possible within criminal justice proceedings. Before this legislation was brought into existence, England and Wales only offered RJ to young offenders, primarily through referral orders (Ministry of Justice, 2012). The RJ program for youth continues to exist, and is based on principles of responsibility, reparation and reintegration (Ministry of Justice, 2012). It was introduced as a measure to decrease reoffending amongst young people who came into contact with the criminal justice system.

As in other parts of the world, RJ in the UK also exists at the grassroots level, and is not solely dependant on the criminal justice system. Other examples of RJ practice include neighbourhood and community mediation schemes, as well as RJ programs run by police and probation officers, such as the Community Resolution program being steered by the Sussex Police Department (*Community Resolution*, n.d.). Although there are currently no RJ programs that work specifically with service users who have mental health issues, there may be some growing interest in processing such cases within the parameters of the forensics system. Recently, there appears to be some discussion about launching a restorative justice program in a forensic unit; however, this endeavor remains in the early stages of development and cannot yet offer any insights into working with this population.

What is mental illness?

A brief history. Before discussing the relevance of mental illness to RJ, it is important to briefly discuss its history. This history is significant for a number of reasons. First, acknowledging it pays homage to those who have been victims of harsh and inhumane attitudes towards mental illness and abnormal behaviour. Second, the history of mental illness acts as a warning, reminding us of the grave ills we have done to individuals who are different. Third, this history has influenced, if not created, present understandings of mental illness and mental health. Lastly, it provides a context for discourse on this subject matter.

It is likely that for as long as there have been societies, there have been individuals who behaved in ways that were deemed unusual or abnormal. In medieval Europe, people sought explanations for such abnormalities through religion and spirituality. Abnormal behaviour, including mental illness, fell under the jurisdiction of the Christian church, which dubbed such behaviours the work of the devil (Davison et al, 2004; Foucault, 1965).

Leading up to the Enlightenment, medicine became an increasingly powerful set of discursive practices aimed at regulating abnormal behaviour. The power of the church on this front dwindled, and this behaviour began to be defined as an illness or disease, a defect within the individual (Scull, 1977). By the fifteenth century, hospitals that had previously housed those sick with leprosy were being converted into psychiatric facilities as the prevalence of leprosy in Europe began to fall with the end of the crusades (Davison et al., 2004). Physicians began to replace the roles of clerics, and by the fifteenth and sixteenth centuries Europe witnessed a major boom in the creation of asylums for the mentally ill (Davison et al., 2004). Political and ideological changes that began to infiltrate Europe

paved the way for confinement, as a means of controlling those deemed abnormal, deficient and disabled (Foucault, 1965; Scull, 1977). These political changes, which idolized work and economic growth, abominated idleness, and in so doing, abhorred all those who were unable to contribute (Foucault, 1965; Pescosolido & Rubin, 2000; Scull, 1977). Idleness became the new leprosy, and the mentally ill, the disabled, the begging poor and those convicted of criminal offences became the new lepers; individuals whose presence in society was unwanted.

For a long time these lunatic asylums were deplorable places, where individuals with mental illness were treated as little more than animals. During the 18th century, increasing value on productivity, efficiency and pursuit of business became a catalyst for what Scull (1977) refers to as the development of a “trade in lunacy” (p.344) in the U.S. Lunatic asylums and ‘madhouses’ began to become privatized in order to generate profit for their owners. At the same time, a similar trend was taking place in Europe. It was during this century that the Bethlehem Asylum in London, England, became one of the city’s greatest tourist attractions, attracting people from all over who came to witness the feral, wild and untamed behaviours of individuals who were unfortunate enough to be confined within its walls (Davison et al., 2004). Though originally opened as a general hospital in 1243, Henry VIII offered it to the City of London in 1546 for the sole purpose of confining individuals with mental illness (Davison et al., 2004). By the 18th and 19th centuries this hospital rivaled the Tower of London and Westminster Abby as a tourist destination, and admission was granted through the sale of entrance tickets (Davison et al., 2004). Mental illness, it seems, became frightening yet sensational entertainment.

During the 17th and 18th centuries, European medical physicians began to study these unusual behaviours, conceptualizing them as pathologies that must be treated (Scull, 1977). This era, known as the Enlightenment, had a significant impact on attitudes toward mental illness (Pescosolido & Rubin, 2000). This was the birth of scientific medicine, which promoted the notion that through science, physicians had the power to treat mental disorders (Pescosolido & Rubin, 2000; Scull, 1977). It was during this time that physicians began to administer experimental treatments that included techniques such as removing large quantities of blood, frightening the patients (nearly) to death and shackling them to the walls within their cells in order to prevent self-harm (Davison et al., 2004).

Pescosolido and Rubin (2000) and Scull (1977) note a similar pattern of socio-environmental influence on mental illness in the United States. They describe a pre-industrial world in which mental illness fell largely under the jurisdiction of family and community. Though lunatic asylums came into existence in the U.S. in 1773 (Davison et al., 2004), they were reserved for individuals who were lonesome strangers, and consequently, had no family or community to fall back on. Pescosolido and Rubin (2000) and Scull (1977) argue that this changed with the emergence of industrialization and a growing popularity of the market economy. New attitudes regarding economics, and the subsequent demographic shifts spurred on by demands for economic growth caused a breach in traditional bonds of family and community, making it difficult for these social institutions to continue providing care. Scull (1977) also notes that the new market economy put greater pressure on a need to differentiate between able-bodied and non-able bodied individuals, since work and productivity began to hold increasing value. Consequently, the institutionalization of individuals with mental illness who were deemed non able-bodied

escalated, continuing well into the 20th century and reaching an all-time high in 1957 (Pescosolido & Rubin, 2000).

It was during the 1950s that word began to spread in the U.S. about the deplorable conditions of psychiatric institutions (Pescosolido & Rubin, 2000). This was also when antipsychotic medication was first introduced (Pescosolido & Rubin, 2000; Davison et al., 2004). With such advances in biochemistry and medicine, this era also witnessed the birth of the biomedical approach to mental illness, which some argue continues to dominate discourse on mental illness to this day (Estroff, 1991; Fee, 2000). Additionally, the 1950s also saw the publication of the first Diagnostic and Statistical Manual (DSM) in 1952 (American Psychiatric Association (APA), 2012), and a subsequent shift toward classifying and categorizing mental disorders in order to facilitate the study of their causality, treatment and epidemiology (Passer & Smith, 2001).

The biomedical approach. According to Hick (2007), the medical model views disability, including mental illness, as an individual health problem that ought to be dealt with medically. To quote Dwight Fee (2000):

“ We live in a world where biomedical and reductionist understandings of mental illness are dominant in scholarly, scientific and psychotherapeutic worldviews and practice. The pervasive viewpoint is that the only way that mental illnesses can be recognized as ‘real’ or worthy of funded research, insurance coverage, rigorous study and...coalition-building, is when they are anchored in the language of bio physiology or some other deep-seated individual factor (p.1)”.

In 1982, John Townsend wrote that the field of psychiatry is rooted on two fundamental assumptions. The first is that mental disorders are diseases that should be

treated. The second is that psychiatric treatments are relatively effective and seldom harmful to the patient (p.786). This attitude is perhaps reflective of the larger biomedical approach to mental illness. The Oxford Dictionary Online (2013) defines medicine as “1) the science of practice of the diagnosis, treatment, and prevention of disease, 2) drug or other preparation for the treatment or prevention of disease” (“Definition of Medicine in English”, para. 1 & 2). Given psychiatry’s positioning as a medical specialty, such conceptualizing of mental illness as an ailment or pathology is not surprising. Townsend (1982) broadens his argument by claiming that within such parameters, psychiatry sees deviant or abnormal behaviour as a disease, and the specific behaviours and mannerisms associated with it as symptoms of a disorder. As a result, psychiatry places the locus of the disease within the individual. Townsend (1982) also supports the argument by Scheff (1963), that psychiatrists are “trained to look for pathology” (p. 789) and that “ symptoms of mental illness generally consist of disruptive behaviour, and although psychiatric treatments may be therapeutic in a biomedical sense, the only concrete evidence that they are therapeutic is that they suppress the disruptive behaviour” (p.793). In other words, he argues that psychiatrist’s roles are generally confined to clinical settings and a reduction of symptoms, and as such, may not be largely involved in incorporating a comprehensive image of the patient’s life.

Another profession that traditionally specializes in mental illness is psychology. Unlike psychiatry, psychology is not a medical specialty, but rather a separate field that specializes in the scientific study of behaviour (Passer & Smith, 2001). As such, psychology is less interested in the diagnosis and treatment of mental disorders, and more likely to consider biological, psychological and environmental factors that interplay on human

behaviour (Passer & Smith, 2001). Nonetheless, like psychiatry, psychology too attempts to categorize human behaviour and is a proponent of the DSM (Passer & Smith, 2001). It does so out of a belief in the necessity of classifying mental illnesses, seeing this an important step in generating discussion about the nature, causes and treatment of mental disorders (Passer & Smith, 2001).

Discussion about the biomedical approach to mental illness would not be complete without recognition of scientific advances in the field of psychopharmacology and neuroscience. Today, a number of physiological contributors to mental illness have been established, although emerging research is increasingly demonstrating that the physiology of mental illness is much more complicated than previously assumed.

It is commonly believed that knowledge about the neurochemical nature of mental illness began to grow with the development of antipsychotic medication during the 1950s. During this era major advances were made with the introduction of antipsychotics such as chlorpromazine and thioxanthene, which diminished positive symptoms in schizophrenia, discussed below (Davison et al., 2004). This, along with emerging anti-institutional attitudes, contributed to a widespread decline in the numbers of inpatients with severe mental illness, as it was believed that patients would be able to manage their symptoms while out in community (Passer & Smith, 2001; Pescolido & Rubin, 2000). Also contributing to this deinstitutionalization was the introduction of disability benefits in the U.S. in 1955 (Whitaker, 2010), and the Canada Pension Plan Disability Benefit (CPPD) in 1966 (Hick, 2007). These enhanced financial opportunities for individuals with mental illness, allowing them to live independently even while their mental illness prevented them from being able to work. Since then, the evolution of antipsychotic medication for the

treatment of schizophrenia and other severe mental illnesses has continued to evolve. Today there is widespread consensus within the medical community that schizophrenia responds well to pharmaceutical treatment and the field of biomedicine is currently witnessing an influx of second-generation antipsychotics that appear to be having a very positive impact (Davison et al., 2004; Kelly, Weiner, Bale, McMahon, Carpenter, & Buchanan, 2009; Passer & Smith, 2001). For example, in a study conducted by Kelly et al., (2008) it was discovered that the drug olanzapine (a second generation antipsychotic) seems to improve cognitive functioning in patients with schizophrenia. Results demonstrated significant improvement in cognitive functioning as well as increase in self-reported quality of life. Findings also revealed a decrease in extrapyramidal symptoms such as akinesia (difficulty initiating movement) and akathisia (difficulty suppressing constant movement), a motor side-effect of chlorpromazine. They also revealed a return of practice effect, which had not been present while subjects were on chlorpromazine. The quality of life measure revealed increases in general health, vitality, social functioning, emotional role and overall mental health.

A similar evolution has occurred with the neurochemical understanding of other mental illnesses, such as depression, also discussed below. Biomedical advances have led to the discovery of low serotonin activity in the synaptic cleft as causal to symptoms of depression (Passer & Smith, 2001). Consequently depression is often treated using selective-serotonin reuptake inhibitors (SSRI), and monoamine oxidase inhibitors (MOA's), which regulate these neuro-chemicals (Davison et al., 2004; Mash & Wolfe, 2005). The neurotransmitter serotonin has also been linked to eating disorders, sleep disorders,

obsessive-compulsive disorder, schizophrenia and other mood disorders including anxiety (Canadian Mental Health Association (CMHA), 2013; Mash & Wolfe, 2005).

Despite evidence supporting a neurochemical basis for mental illness, some contemporary research is questioning an over-zealous reliance on medication. In his book *Anatomy of an Epidemic*, Robert Whitaker (2010) claims that in spite of scientific advancement in this area, rates of individuals with mental illness in the U.S. have boomed since the development of antipsychotic medication. His research shows that the number of people with mental illness on disability in 2007 was 1 in 76, which was twice as many as in 1987 and six times as many as in 1955 when these services were first introduced in the US. Additionally, he argues that rates of depression and bipolar disorder have increased dramatically since the 1990s, which coincides with the development of Prozac in 1987. Furthermore, Whitaker's (2010) research shows that up to 75% of patients with schizophrenia were recovering and being discharged from psychiatric hospitals before antipsychotic medication was even introduced. Only 20% were in need of long-term hospitalization. Consequently he opposes the belief that antipsychotic medication revolutionized the treatment of mental illness, since his data implies that recovery rates were already quite high to begin with. Though he generally supports the use of pharmaceuticals, he cautions against their long-term use and disagrees that second generation antipsychotics are having a more positive impact than their predecessors. He points out that side effects are severe, and that long-term use of such drugs can be harmful to normal brain functioning. Additionally, he strongly argues that many other variables, such as a healthier lifestyle and increased exercise, can lead to recovery from mental illness. As a result, he asserts that pharmacological treatment is not the only answer.

A 2002 study by Kirsch, Moore, Scoboria and Nicholls appears to support Whitaker's stance. Results of this study revealed that 80% of response to antidepressant medication was replicated in a placebo control group, suggesting that much of the success attributed to antidepressants may actually be the result of a placebo effect. Furthermore, findings also revealed that improvement levels were the same regardless of dosage, demonstrating that the amount of antidepressant that a participant received did not appear to affect recovery.

Physiological explanations for mental disorders, along with a desire to categorize and classify them, have generated the development of diagnostic manuals such as the DSM and the International Classification of Disease (ICD). These manuals, first created in the 1950s (APA, 2012; Drescher, 2010) attempt to provide definitions of mental disorders, and compartmentalize symptoms into groups or clusters (Davison et al., 2004; Passer & Smith, 2001). Although the DSM and ICD recognize numerous mental health diagnoses, perhaps the greatest attention is often given to disorders that qualify as serious and persistent. There is some disagreement about which mental health diagnoses should be included in the serious and persistent mental illness category; however most experts agree that thought disorders, mood disorders and personality disorders such as schizophrenia, severe depression, bipolar disorder and borderline personality disorder warrant such inclusion (Bednar, n.d.; Estroff, Lachicotte, Illingworth, & Johnston, 1991). These diagnostic entities are briefly discussed below.

Schizophrenia. Schizophrenia is perhaps one of the most commonly occurring thought disorders in Canada (Public Health Agency of Canada, 2012). It affects approximately 1% of the Canadian population (Health Canada, 2002; Public Health Agency of Canada, 2012) and is equally prevalent in men and women (Davison et al., 2004). The

onset of schizophrenia generally occurs in late adolescence or early adulthood, and it can persist as a chronic condition throughout the individual's life (Davison et al., 2004). It can also be diagnosed during childhood as childhood-onset schizophrenia (Mash & Wolfe, 2005). Schizophrenia is most commonly characterized by disturbances in thought, emotion and behaviour as well as withdrawal from reality (Davison et al., 2004; Mash & Wolfe, 2005; Passer & Smith, 2001). Individuals with this mental illness often become governed by their hallucinations and delusions and struggle with social interaction and general life functioning (Davison et al., 2004; Mash & Wolfe, 2005; Passer & Smith, 2001). Symptoms can also cause difficulties with thinking clearly, following direction, acquiring new information and developing new skills (Stratta, Donda, Rossi, & Rossi, 2005). Furthermore it is also believed that schizophrenia contributes to the development of a neurocognitive impairment, which in turn can have a severe impact on the individual's ability to maintain an independent life (Stratta et al., 2005).

A symptom of schizophrenia that can be particularly debilitating is psychosis. Psychosis is characterized by an onset of odd beliefs, altered perceptions, distressing emotions, including heightened anxiety and sensory perception, (Kapur, 2003) as well as an overall loss of contact with reality (Fraser Health, 2013). According to Fraser Health (2013), 3% of the population can expect to experience at least one episode of psychosis during their lifetime. Although most commonly associated with schizophrenia, psychosis has also been known to occur in individuals with mania or those who have experienced chronic use of amphetamines (Kapur, 2003). Its onset is rarely sudden, and is generally believed to progress gradually in stages (Fraser Health, 2013; Kapur, 2003). Psychosis is also usually recurring (Kapur, 2003).

Although some would disagree (Foussias & Remington, 2010; Whitaker, 2010), many experts believe that treatment of schizophrenia has seen major advancement since the creation of first generation antipsychotics in the 1950s (Davison et al., 2004). Today, the use of antipsychotic medication continues. Many believe that pharmaceutical treatment has progressed and witnessed increasing success with regards to symptom management (Davison et al., 2004; Kelly et al., 2009; Mash & Wolfe, 2005).

Treatment is especially necessary for psychosis. Though science is continuously studying the biochemical nature of this symptom, antipsychotic medication, which regulates dopamine levels in the brain, appears most effective at this time (Fraser Health, 2013; Kapur, 2003). This is especially true when provided in combination with psychotherapy (Kapur, 2003). As a result, Fraser Health's (2013) Early Psychosis Intervention Program (EPI) asserts that psychosis is treatable, and that recovery is expected.

There is some indication that Whitaker (2010) is valid in believing that second-generation antipsychotics are no more effective in treating schizophrenia than those developed in the 1950s. A study conducted by Foussias & Remington (2010) detected no difference in effectiveness between first-generation and second-generation antipsychotics, giving reason to contest the notion that second-generation antipsychotics are superior to first-generation ones.

Mood disorders. Mood disorders are characterized by the presence of disabling mood fluctuations, such as extreme sadness or total elation and euphoria (Davison et al., 2004; Passer & Smith, 2001). These emotional experiences are generally very intense and exaggerated, and can therefore powerfully impact the individual's physical health, mental

wellness and behaviour (CMHA, 2012). Mood disorders are quite common, thought to occur in approximately 10% of Canadians (CMHA, 2012). Two of the most commonly occurring mood disorders are bipolar disorder and severe depression, occurring in 1% and 8 % of the population, respectively (CMHA, 2012; Health Canada, 2002)

Mood disorders are commonly treated using a bio-psycho-social approach, which combines the use of pharmaceuticals with counseling therapy. Perhaps one of the most popular psychological treatments of mood disorders is the cognitive-behavioural approach (CBT). Therapists using CBT focus on the modification of behaviour through the alteration of cognitions (Davison et al., 2004). The combination of antidepressant therapy with psychological counseling remains best practice. Siddique, Brown, Chung and Miranda (2012) found that patients with depression who received CBT fared better and had longer lasting effects than patients who were treated with medication alone. Overall, their results demonstrated that patients who received CBT treatment were less likely to relapse over the following year, possibly due to having learned a set of adaptive coping skills that helped them maintain their mental health.

Personality disorders. Diagnoses that fall under the category of personality disorders are characterized by behaviour patterns that deviate from what would be considered the norm, in light of societal expectations. These behaviour patterns are generally static, inflexible and extreme, and can make it difficult for individuals to adapt to the world around them (CMHA, 2004; Davison et al., 2004; Passer & Smith, 2001). A report by Health Canada (2002) claims that Canadian statistics on personality disorders are lacking, but that US statistics point to a prevalence that may be as high as 6%-9%.

Although the same report notes that as many as 50% of prisoners may have anti-social

personality disorder, one of the more commonly occurring personality disorders in the general public is borderline personality disorder (BPD), which has a prevalence of 1% (Davison et al., 2004).

Perhaps one of the best-known treatments for BPD is dialectic behaviour therapy (DBT). Like CBT, DBT is also a cognitive-behavioural approach, which focuses on the alteration of maladaptive thinking patterns. It was developed by Marsha Linehan specifically for the treatment of individuals with BPD, and is widely supported by empirical evidence (Rivvi, Stefferl, Carson-Wong, 2012). DBT combines biological, psychological, environmental, sociological and behavioural approaches to treatment, introducing a more holistic approach.

This brief review of biomedical understandings of mental illness is presented in contrast to a social constructivist one, to which this paper now turns.

The social constructionist approach. A social constructionist approach takes the stance that when discussing mental illness it is impossible to ignore its connectedness to abnormal behaviour, and the subjectivity of determining what behaviour warrants such a label. This approach assumes that knowledge, including knowledge about one's reality, is socially constructed. As such, it opposes the position that knowledge is a static, tangible and naturally existing object. Relating to mental illness, it fundamentally rejects the notion that mental illness exists as a condition in and of itself (Coulter, 2001). Rather it sees mental illness as an object or phenomenon that is produced by the social world in which it exists.

Jeff Coulter (20010) explains that social constructionism relates to the construction of beliefs, not just facts about the world. This explains why definitions of normal and

abnormal behaviour vary across cultures and societies, and why they have changed over time. He also describes social constructionism as closely associated with labeling theory, which maintains that society places labels on individuals whose behaviours it considers deviant or outside the range of standard cultural norms (Scheff, 1974). These labels can persist throughout an individual's life, often manifesting as stigma and stereotype (Scheff, 1974). When viewing disability through this lens, one must accept the position that disability exists only as long as society "maintains barriers to full participation of people who are physically or mentally different" (Hick, 2007, p.313). Consequently, it is through changes in society, not in the individual, that barriers and disadvantages can be altered or removed.

Three psychologists, Davison, Neale and Kring (2004) claim that abnormal behaviour can be assessed when there is deviation from the norm on matters such as conformity to societal norms, levels of emotional distress, existence of disability and behavioural dysfunction, and unexpected behavioural responses that are outside of what would be expected under given circumstance. The last point, labeled by the authors as "unexpectedness", refers to a behavioural or emotional response that is incongruent with a given environmental stressor. For example, when an individual who is financially stable worries incessantly about his or her financial situation (p.5). This definition assumes that abnormality can be determined when a behaviour is statistically outside the range of what would be considered normal. In other words, a behaviour becomes abnormal when the majority does not exhibit it. Though taking a statistical approach to mental illness rather than a social constructionist one, this definition of abnormal behaviour cannot depart from defining mental illness as a product of biological, sociological, environmental and

psychological factors. As a result, it is easy to speculate that the assessment of what constitutes abnormal behaviour is vague, subjective and culturally diverse.

Passer and Smith (2001) support this view, stating that “judgments about where the line between normal and abnormal should be drawn differ depending on the time and culture” (p.589), and that definitions of abnormality are influenced by values and political agendas. Consequently, they support the perspective that “abnormality is, in the final analysis, a social construction” (p.589). Nonetheless, where abnormality and mental illness intersect is another issue, and in this case, Passer and Smith (2001) provide a similar explanation to that of Davison et al. (2004). They claim that abnormal behaviour exists and warrants inclusion as mental illness when the behaviour is dysfunctional (either for the individual or society), distressing and deviant. Deviance, a contestable and arbitrary construct, is perhaps the most subjective of the three, as it is governed by social norms and values that dictate how individuals within a society should behave. As such, Passer & Smith (2001) subjectively define deviant behavior as a mannerism that is “so culturally deviant that other people judge it to be inappropriate or maladaptive” (p.590).

Since definitions of abnormal behaviour appear to be reliant on cultural norms and values, the interplay between them and the sociopolitical environment cannot be overlooked. Fee (2000) describes mental illness as a *social object*, and questions those who assume that mental illnesses is something that is “simply out (or in) there” (p.2). He traces these assumptions back to the Enlightenment, arguing that it was during this time that mental disorders began to be conceptualized as alien and irrational sicknesses, which existed in and of themselves, and could only be rectified through scientific intervention and treatment. He disagrees with such a view, and strongly argues that mental illness cannot

exist independent of the larger context of history, politics and culture, despite scientific evidence of its neurochemical origins. Instead he claims that mental pathology is both a socio-historical and linguistic construction, as well as a real debilitating condition with physiological underpinnings. Pescosolido and Rubin (2000) also share this perspective, stating that one must acknowledge and assess the influences of macro systems on micro-level experiences, since the two do not, and perhaps cannot, live in exclusion of one another.

Foucault, in his book *Madness and Civilization* (1965), discussed the connection between mental illness and society. His argument portrays mental illness as engaged in a symbiotic relationship with society, characterized as fluid, ever-changing, and dependant on societal norms and expectations. Foucault travels through time, and reveals how shifts in ideologies, politics and definitions of what it means to be human conceptualized how individuals with mental illness were treated, and how unusual behaviour was defined. He describes a sort of evolution that commences with a religiously driven approach, which demonized mental illness and aroused fear of death, to a more complex analysis of the duality of body and soul, and analysis of wakefulness and dreaming. He also pays heed to shifts in power, and how these influenced society on the whole. He describes the power of the church, and the subsequent power of science and morality in the post-Enlightenment era. He also speaks of Freud, and argues that psychoanalysis and its ability to engage with the subconscious proved pivotal in transferring power from asylums and institutions to medical professionals, namely psychiatrists.

Following Foucault's analysis, one could argue that the evolution has continued. There has been increasing study and development in biology and psychopharmacology,

leading to the advances in treatment of the body. Science and medicine have also continued to dominate the discourse on mental illness throughout the twentieth and twenty-first centuries, upholding the power of psychiatrists and mental health experts (Estroff et al., 1991; Fee, 2000). However, changes in society have also contributed to shifts in ways of thinking about mental illness. One example of this in recent history is the case regarding homosexuality.

Up until 1973 homosexuality was listed in the DSM as a sexual deviation, based on the popular assumption that all individuals who were gay desired a sexual reorientation that would permit them to become heterosexual (Davison et al., 2004; Drescher, 2010). Following immense pressure from gay rights groups and other mental health professionals, including young psychiatrists with progressive ideas (Drescher, 2010), the American Psychiatric Association (APA) was eventually forced to change this diagnosis. In the early years of the DSM, dominant social norms and attitudes regarding homosexuality hindered the APA's willingness to enter into serious dialogue about eliminating it as a mental disorder. Ultimately, following massive debate and protest by gay right's activists in the late 1960s and early 1970s, the diagnosis of homosexuality was removed, and a new diagnosis called sexual-orientation disturbance was created (Drescher, 2010). This new diagnosis was designed to include individuals who were gay, but felt distressed and wished to become heterosexual (Davison et al., 2004; Drescher, 2010). In 1980 the creators of the DSM-III (APA, 2012) revised this diagnosis yet again, creating the diagnosis of ego-dystonic homosexuality; however remained cautious about eliminating homosexuality as a mental disorder altogether (Drescher, 2010). It wasn't until the creation of the DSM-IV in 1994 (APA, 2012) that homosexuality was entirely erased from the manual, again reflecting the

changing social norms, values and attitudes toward this behaviour (Davison et al., 2004; Drescher, 2010). Today, one can speculate that the idea of homosexuality as a mental illness would likely seem outrageous to most people living in Canada.

The power that such societal shifts in thinking have on defining mental illness continues to be evident in the most recent version of the DSM, which increasingly presents as a subjective and fluid diagnostic source that is representative but also dependant on the interplay between society and definitions of normal and abnormal behaviour. Though continuing to uphold the notion that mental illnesses are disorders that must be treated, the creators of the DSM V chose to incorporate an increasing number of mental health spectrums in order to pay credence to the variability of symptoms, rather than remain within the confines of black and white mental health diagnoses (APA, 2013). Certain disorders, such as autism and Asperger's syndrome were merged into one, as were all the subtypes that previously existed for schizophrenia (APA, 2013). Additionally, certain words were changed or removed in order to reflect shifts in contemporary language. Examples include the removal of the terms 'mental retardation' and 'stuttering' and their replacement with 'intellectual disability' and 'childhood-onset fluency disorder' in order to reflect widespread use of this new terminology amongst professionals and advocacy groups (APA, 2013). These alterations support and demonstrate the fluidity of mental health diagnoses, and highlight the influence that society has on such manuals.

It appears that the Canadian Mental Health Association (CMHA) is also becoming aware of changing perspectives. The organization has recently launched a new Strategic Plan 2012-2017, in which it acknowledges that attitudes about mental illness are shifting. It points to enhanced media exposure as a catalyst for raising awareness about mental

illness, and claims: “There’s a greater societal recognition of, and attention to, mental health and mental illness” (p.4). The CMHA also recognizes the monumental importance of the recent development of Canada’s first-ever mental health strategy, and the mass consultation with individuals in the mental health community that led to its creation. Following copious amounts of interviews with service users, it appears that Canada may have a mental health strategy that has been largely user-led. A quote by one of the individuals interviewed by the CMHA encompasses the present changes in attitudes toward mental illness: “To eliminate or reduce stigma associated with mental illness we have to peel back the layers of taboo and get people talking. It’s perfectly acceptable and normal to talk about mental illness” (p.4)

Perhaps one of the places where major change in attitude may be presently occurring is with post-traumatic stress disorder. There appears to be widespread acknowledgement that trauma is justification for behaviours associated with the diagnosis of PTSD, and awareness regarding the emotional and physiological impacts of trauma may be growing.

In the weeks following the 2001 terrorism attacks on the World Trade Centre in New York, preliminary surveys revealed that approximately 520, 000 New York residents were experiencing symptoms of PTSD as a direct result of the trauma induced by the attacks, and another 3.1 million were experiencing heavy emotional distress (Felton, 2002). Consequently, the New York State Office of Mental Health launched a free mental health service to all residents of New York, providing public education about trauma, stress and coping strategies, as well as free counseling (Felton, 2002). One of the main strategies of this mental health program was to normalize the symptoms that people were experiencing,

enforcing that extreme grief, stress and sadness were normal reactions to such an event. Services were also made available to those whose traumatic symptoms persisted, and consequently warranted a diagnosis of PTSD. Again, the diagnosing of PTSD amongst these individuals was normalized. Interestingly, program coordinators chose to name the program Project Liberty, in order to detach it from conventional mental health treatment schemes. Phrases such as “mental health treatment” or “mental health program” were strategically dismissed due to fears that stigma would prevent New Yorkers from engaging with the program. Program coordinators chose to discuss symptoms instead of diagnoses, and found this method far more successful, and more conducive to normalizing symptoms associated with trauma.

Along similar lines, in 2001 the Canadian Department of National Defense partnered with Veteran’s Affairs Canada to create the Operational Stress Injury Support Program (2012). This non-clinical peer support program offers support for Canadian veterans who are living with symptoms of PTSD. These peer support services are made available to veterans as well as to their families. Interestingly, the term ‘operational stress injury (OSI)’ is used instead of PTSD or trauma. Given the apprehensions regarding stigma as discussed by Felton (2002), it is plausible that the rationale for using different terminology also stems from concerns surrounding this issue.

Despite some evidence pointing to stigma against the term PTSD, an Australian study by Reavley and Jorm (2011) showed an increased acceptance of PTSD when compared with other mental illnesses. Over six thousand participants were presented with vignettes describing different mental illnesses. Attitudes toward PTSD appeared the least stigmatizing when compared with other diagnoses. Reavley and Jorm (2011) speculate

that this could have been due to widespread understanding that symptoms of PTSD are caused by an external source, and consequently, individuals exhibiting such symptoms are deemed less blameworthy.

Yet another study by Gould, Greenberg and Hetherton (2007) explored attitudes about trauma in the UK military. Researchers evaluated the trauma risk management (TRiM) program, which was developed by the Royal Navy as a campaign for promoting help-seeking behaviours and a normalization of symptoms relating to PTSD. The aim was to challenge old-fashioned beliefs, which stated that any soldier who sought help and counselling following a traumatic event was weak and feeble. The TRiM program used education and personal contact with individuals who have PTSD as the main source of operation, and found these strategies to be successful. Program coordinators and researchers found a decrease in negative stereotyping as well as an increase in help-seeking behaviours following the launch of the campaign. Interestingly, researchers also discovered that attitudes toward PTSD and symptoms of trauma were generally positive at baseline; however it appeared that cultural norms, which belittled such attitudes, hindered the participant's willingness to express these beliefs. The effects of stigma will be discussed in greater detail below.

Psychosocial Rehabilitation and Recovery

The last few decades have witnessed what some might consider a revolution in the way that mental illness has begun to be conceptualized by the mental health community. The success of recent drug therapies as well as a shift toward more holistic approaches to treatment has contributed to the emergence of a Psychosocial Rehabilitation (PSR) model as well as an acceptance of recovery in mental illness (CMHA, 2012; Kelly et al., 2009;

Mental Health Commission of Canada, 2012; World Health Organization (WHO), 1996). In fact, one could argue that PSR amalgamates certain aspects of the biomedical and social constructionist approaches, paying heed to bio-socio-psychological determinants of mental illness and wellness.

PSR was first developed and practiced in hospital settings; however it has since grown into a paradigm that encompasses all individuals living with mental illness, whether hospitalized or not (WHO, 1996). Not only does PSR offer a new way of defining mental illness but it also provides a new way of organizing services and resources. Services that follow this model focus on prevention and reduction strategies in the hopes of challenging some of the barriers and constraints that traditionally accompany mental illness (WHO, 1996). These strategies use a bio-psycho-social approach to create an environment that is opportunistic and conducive to individuals with mental illness. The aim is to permit these individuals to reach their optimal level of independent functioning in the community (Mental Health Commission of Canada, 2011;WHO, 1996). It is consequently a philosophy that encompasses all levels of mental health practice, from micro to mezzo to macro.

In practice, PSR aspires to maximize continuity of care and treatment, and to recognize an individual's strengths and capacity for autonomy and self-determination (WHO, 1996). It is a holistic way of looking at mental illness, combining the use of therapy and pharmaceuticals with independent life skills, family and community involvement (WHO, 1996). The principles of PSR are grounded on the right to dignity, worth and quality of life and the belief that recovery is possible (CMHA, 2012; Mental Health Commission of Canada, 2012). The Mental Health Strategy for Canada (2012) asserts that even individuals with the most severe mental illnesses can obtain good mental health and achieve recovery.

Recovery is not synonymous with 'cure' but rather is a concept based on notions of hope, empowerment, self-determination, responsibility and values of dignity, respect and autonomy (Mental Health Commission of Canada, 2012). The Mental Health Commission of Canada (2011) claims that no single definition of recovery is possible because there is no neatly defined path to it; recovery is unique for every individual. The Commission also reminds us that a person can recover his or her life without recovering from the illness, and consequently, the definition of recovery must remain subjective and open to individual interpretation.

Although there is no agreed-upon definition of 'recovery' there is some consensus about what its key components are (Mental Health Commission of Canada, 2011). Recovery is rooted in hope, which is defined as believing in oneself and having a sense of optimism in one's ability to accomplish things. It is also rooted in re-establishing a positive sense of identity and a positive view of self. In addition, recovery is also grounded on the notion that every individual has the right to build a meaningful life, despite the existence of a mental illness. Lastly, recovery emphasizes taking control of one's life, one's illness and one's destiny, accordingly placing value in self-determination and autonomy.

In 2003 a team of mental health experts was assembled in order to test the boundaries of the recovery model and compile a definition of the term 'remission' in schizophrenia (Andreasen, Carpenter, Kane, Lasser, Marder, & Weinberger, 2005; Kelly et al., 2009). These experts, who were all psychiatrists, formed a working group and eventually succeeded in reaching consensus on this issue. Their new definition of the term 'remission' underlines a similar collection of values to those mentioned above but pushes a more positivist approach to the concept, focusing on the reduction of symptoms. They

defined remission in schizophrenia as a state in which the symptoms of the illness are of such low intensity that they no longer interfere significantly with daily living, and that they are below what would typically be used to make a schizophrenia diagnosis (Andreasen et al, 2005). According to the Mental Health Commission of Canada (2011), approximately 25% of individuals diagnosed with a serious mental illness would meet these criteria.

Stigma

Despite improved outcomes and an obvious paradigm shift within the mental health community there is one obstacle that continues to plague individuals with mental illness and hinder the potential for recovery and social inclusion. This obstacle is social stigma. Stigma has been defined as “negative stereotypes and prejudices about people with mental illness, ...that are a widespread phenomenon with damaging social, psychological and economic consequences” (Eisenberg, Downs, & Golberstein, 2012, p.1122). It can have very negative impacts on quality of life and appears to be especially negative towards individuals with schizophrenia when compared with other mental illnesses (Norman, Sorrentino, Windell, & Manchanda, 2008; Revley & Jorm, 2011; Sadler, Meagor, & Kaye, 2012). According to a study conducted by Norman et al. (2008), individuals with schizophrenia were perceived as highly dangerous and socially inappropriate. The results demonstrated that subjects preferred to keep these individuals at a distance. Although subjects were less likely to assign blame for the illness to individuals with schizophrenia than to those with depression, results also imply that individuals with depression are more socially accepted than those with schizophrenia. Interestingly the higher the amount of experience with people with schizophrenia, the lower the perception of danger,

demonstrating perhaps the degree of negative stereotyping that is associated with this illness.

The study by Reavley and Jorm (2011) highlighted similar results. Individuals with schizophrenia were most likely to be considered dangerous, unpredictable and unemployable when compared with other mental illnesses. Interestingly, researchers also found a relatively high degree of stigma directed at social phobia. Participants generally believed that social phobia was not a real mental illness and consequently, such behaviour was deemed the result of personal weakness.

Further evidence of the severity of stigma that is associated specifically with schizophrenia can be seen in the results of a study conducted by Sadler et al. (2012). These showed that individuals with schizophrenia were rated as more hostile and incompetent when compared with people with other mental illnesses. It is also interesting to note that 22% of subjects in this study also identified violent crime as a mental illness, and 14% identified homelessness. These figures are telling and may indicate a lack of education and knowledge about mental illness in the general public. Homeless individuals as well as those with addictions were placed in the same category as schizophrenia: the most hostile and least capable. All three received the lowest ratings on measures of warmth and competence. Warmth was defined as a measure of perceived intention. The intention could be either malicious or beneficent.

Anna Scheyett (2005), a social worker, studied stigma and found it to be quite pervasive. Her research revealed that a survey conducted in the US uncovered that 70% of respondents did not want someone with depression to marry into their family, and only 19% of participants from another survey admitted to feeling comfortable around people

with mental illness. Some of the other studies that Scheyett (2005) looked at revealed that mothers were more comfortable leaving their children in the care of an “ex-con” than a person with a mental illness, and that 39% of Australian psychiatrists said that they would prefer not to work with individuals with intellectual disabilities or mental illness (Chaplin, 2000; Lennox & Chaplin, 1996).

Given the seemingly low level of knowledge about mental illness in the general public, it may be possible that stigma is mainly directed at the diagnosis, rather than the symptoms themselves. Evidence appears to suggest that despite being highly stigmatizing toward mental health diagnoses, the general public may have little knowledge about symptomology and the behaviours associated with the label. In a time when norms and values about behaviour appear to be changing, one must wonder whether this latter point has significant implications for reducing stigma and normalizing mental illness through education.

It is also possible that the negative stereotypes of dangerousness and violence stem from the overrepresentation of offenders with mental illness in the criminal justice system. The Mental Health Commission of Canada (2012) claims that the proportion of offenders with mental illness is greater than the proportion in the general public. Although the majority of individuals with mental illness are not affiliated with the criminal justice system, a lack of resources, along with a shift toward deinstitutionalization, has made this connection stronger (Mental Health Commission of Canada, 2012). According to the Mental Health Commission of Canada (2012), rates of offenders with serious mental illness in the federal system have increased by 60% to 70% since 1997, largely due to inadequate re-investment in community mental health resources that could provide support for those

who were deinstitutionalized. In its attempt to remedy this injustice the Mental Health Commission of Canada lists several possible solutions. One of these solutions is diversion from traditional criminal justice to restorative justice.

A large body of stigma-related literature pays special attention to a phenomenon known as internalized stigma. Internalized stigma is the process by which negative stereotypes that devalue and discriminate become internalized. This can lead to self-stigma, which is a process that occurs when there is awareness of the stereotype, agreement with the stereotype and application of it to oneself (Corrigan, Larson, & Rusch, 2009, p.75). Self-stigma has been associated with low self-esteem and low self-efficacy, as well as the development of what Corrigan et al. (2009) refer to as the “why-try” effect. The “why-try” effect occurs when there is: 1) an internalization of stereotypes about mental illness, 2) a subsequent decrease in the individual’s sense of self-esteem and self-efficacy, 3) and a weakened drive for the pursuit of life goals, dreams and aspirations. These three factors result in many individuals with mental illness losing their desire to improve their life circumstances and pursue personal goals and aspirations. As a result, these individuals often disengage from opportunities that could improve their housing, finances and overall self-satisfaction. Internalized stigma may shed some light on why approximately 49% of Canadians who self-identify as having depression have never gone to see a doctor for it (CMHA, 2012).

The discussion on stigma opens the door for generating ideas about how to fight it. Scheyett (2005) identified protest, education and personal contact as three techniques commonly used to fight stigma. She argues that personal contact is most effective in reducing stigma, followed by education. This supports the aforementioned observations

made by Norman et al. (2008), which found that personal contact with individuals with schizophrenia decreased negative perceptions of dangerousness. It also explains the success of the Royal Navy's TRiM program (Gould et al., 2007). A study by Eisenberg et al. (2012) also supports this claim, again emphasizing that a combination of personal contact with education is best, rather than personal contact alone. Here, university students were followed during one academic year in order to assess whether their attitudes regarding mental illness changed if their roommate developed a mental illness. The expectation was that stigma would decrease due to the intimate nature of such a relationship. Surprisingly, findings demonstrated a general increase in stigma; however, it was noted that the majority of participants had little education and experience with mental illness at the study's onset, and consequently, may have struggled to understand their roommate's altered behaviour. Students who had prior knowledge or experience with mental illness did not follow the same pattern.

Brown, Evans and Espenschade (2010) also studied two stigma reduction strategies, filmed personal contact and hallucination simulations, in order to assess which technique was more successful in reducing stigma. They found that participants who watched the film expressed a decrease in stigma and negative stereotyping, while those who underwent hallucination simulations demonstrated an increase. Brown et al. (2010) interpret these results by claiming that education about mental illness would have likely increased the success of the simulation intervention since participants would have been better prepared, and consequently, less frightened by it. These findings suggest that education along with initiatives that put a face to mental illness humanize the individual, and in so doing, decreases stigma.

Restorative Justice and Social Work

There are many parallels between restorative justice values and those of the social work profession. As a result there is strong incentive for social workers to become increasingly involved in RJ practices. RJ exemplifies notions of empowerment and self-determination as well as peacemaking, empathy and a strengths-based approach (Van Wormer, 2004). The goal of RJ is to reconnect individuals with their communities rather than isolate and disown them (Van Wormer, 2004). As a result RJ is also rooted in values of inclusivity and acceptance. For social workers these values should be reminiscent of our own. The first four core values of the Canadian Association of Social Workers are 1) respect for inherent dignity and worth of persons, 2) pursuit of social justice, 3) service to humanity and 4) integrity of professional practice (Canadian Association of Social Workers, 2005). Restorative justice creates a platform that is welcoming of these core values and in so doing is welcoming of social workers.

Restorative Justice and Mental Health

The combination of RJ and mental health is a relatively new and unexplored field of practice. Although it has been identified as a possible measure for decreasing the overrepresentation of individuals with mental illness in the criminal justice system (Mental Health Commission of Canada, 2012), there exists minimal literature on this topic and it remains largely underdeveloped. Exploring the wisdom of RJ practitioners who have worked with service users who have serious and persistent mental illness may yield important implications for RJ and its relationship with mental health services. It may also provide insight into the needs, skills, and capacities of those with serious mental illness and contribute to the expansion of knowledge for RJ practitioners. The purpose of this study

was to expand on this area of practice by conducting three interviews with RJ practitioners who have processed cases with service users who have mental illness. This study set out to learn about their experiences, and to hear practitioners' perspectives about conducting RJ with this population. The hope was to generate implications for social work practice and practitioner development.

Method

This study underwent numerous revisions with regard to methodology and recruitment. These changes occurred largely due to an unexpected shortage of participants, pointing to a possible gap in restorative justice practice, and giving credence to the novelty of this area of research. The project launched with ambitions of narrative discourse and participatory action. Unfortunately, this objective was eventually abandoned as it became clear that despite various recruitment strategies, no service users were coming forward to be interviewed. Attention shifted to RJ practitioners, pursuing a curiosity about why service users with serious mental illness had been so difficult to locate. Following its final amendment, the study took a qualitative descriptive approach, working under the epistemological framework of critical theory. The belief that research should be used to inspire social change was at the core of this endeavor, as was the desire for advocacy and promotion of social inclusion for individuals with serious mental illness. This study attempted to describe the voices of participants with genuine authenticity, subsequently focusing on the facts, but also situating them within a larger context.

Sampling

Sampling took a purposeful approach. Initial recruitment consisted of service users with serious and persistent mental illness who had undergone a RJ process. Recruitment flyers were distributed throughout mental health clubhouses and services in Vancouver and the Lower Mainland, specifically with the help of agencies such as the Canadian Mental Health Association-Vancouver/Burnaby Branch and Fraserside Community Service Society. In addition, word about the study was propagated amongst the RJ community, with the hopes that practitioners would pass information about the study along to service users

who met criteria. Unfortunately six months of rigorous recruitment yielded no results, and evidence of a major gap in RJ practice seemed to be emerging. At the same time it was discovered that the UK appeared to be witnessing a major increase in RJ practice following recent changes to legislation, and the landscape appeared more fruitful for recruitment. Consequently, recruitment was moved to the United Kingdom, in the hopes that insights and recommendations could be brought back for RJ practice in Canada.

Initial recruitment attempts were also discouraging; no service users came forward. Eventually, as recommended by Sandelowski (2000), recruitment criteria were altered yet again in order to obtain a more variable sample, subsequently encompassing a wider range of participants, including RJ practitioners. The final recruitment criteria consisted of individuals over the age of nineteen, who identified as being in good mental health and in recovery, who spoke English well enough to be interviewed, and who met one of the following criteria: A) a service user with a previous diagnosis of serious and persistent mental illness who had successfully completed a restorative justice process (success was defined as completing the process, not as verbalizing satisfaction or dissatisfaction with the outcome); B) a service user with a previous diagnosis of a serious and persistent mental illness who had not yet completed a restorative justice process but had expressed interest in doing so; C) a restorative justice practitioner who had conducted at least one restorative justice process with a service user who had serious and persistent mental illness and; D) a service user (victim or offender) who did not have a serious and persistent mental illness but had expressed interest in entering into an RJ process with a person that did. Three practitioners volunteered to participate in the study. It remained unclear why there appeared to be such a lack of interest in the study, and why only three participants came

forward. There is speculation that this may have been representative of a shortage of practice in this area, and a subsequent scarcity of individuals who have encountered serious and persistent mental illness within the context of RJ. Recruitment ended when time restrictions intervened and I returned to Canada.

Participants were RJ practitioners with varying degrees of experience. All had conducted numerous RJ processes, several of them with individuals with serious and persistent mental illness. Two had primarily practiced victim-offender conferencing while the third had a strong background in neighbourhood mediation. The participant who practiced neighbourhood mediation was also a RJ trainer, and worked in mental health outside of her RJ work. All participants had practiced in England, UK.

Data Collection

Data were collected using semi-structured interviews. Two interviews were conducted in person, at a location of the participant's choosing. The third was conducted over the phone, as an in-person interview was not possible. All participants signed consent forms prior to taking part in the interviews. Interviews lasted approximately one hour and were audio-recorded. As advised by Sandelowski (2000) interviews included moderately structured open-ended questions, and participants were given opportunity to direct the conversation. Consequently, interviews were variable and differed from one another as each participant led the conversation down a slightly different path. This was encouraged in order to generate fruitful data. Questions were also continuously modified following each interview in order to accommodate emerging data.

Data Analysis

Qualitative content analysis was used for the analysis of data (Sandelowski, 2000). Effort was made to ensure descriptive and interpretive validity. Data were therefore analyzed in a way that authenticated participant's voices and stayed true to the facts. Both verbal and visual data were recorded and considered. I myself transcribed all interviews, transcribing all words verbatim. This was done in order to become better acquainted with the data and more immersed in its content. Transcripts were later compared, and repeating ideas were noted. These were clustered into categories, and several themes were identified.

Findings

Prevalence of Mental Illness in RJ Cases

Prevalence. According to data collected from interviews, the likelihood for a practitioner to encounter mental health issues during a restorative justice conference may be quite high. Although the numbers vary and have not been quantified, participants reported a prevalence of mental illness that ranged from 20% to 90%. One participant, here named John, asserted that approximately 90% of participants in his victim-offender conferencing pilot project appeared to have mental illness, although no data were kept on this, resulting in a shortage of statistical figures to support his claim. John observed that many service users in his project had a formal diagnoses, the most prevalent being schizophrenia, followed by severe depression and bipolar disorder. Another participant, Susan, stressed that she encountered numerous service users with mental health issues in her work conducting neighbourhood mediation. She contended that working with service users who have mental illness is simply part of the job.

Link to deinstitutionalization. Interestingly, data also pointed to a link between the deinstitutionalization movement and an increase in offenders with mental health issues. One participant, Max, who was a police officer as well as a RJ practitioner, expressed that he had witnessed an evident influx in the numbers of individuals with mental illness who had come into contact with the criminal justice system. This influx, he said, appeared to correlate with the closing of psychiatric institutions in the UK. Consequently he argued that the numbers of offenders with mental health issues eligible for victim-offender mediation schemes likely also increased with the change in population.

The connection to the deinstitutionalization movement was also discussed by Susan, the neighbourhood mediator. Susan explained that it is customary to receive a case in which at least one of the disputing parties has a mental illness, and is evidently struggling with it while living independently. She said that these individuals can cause “quite a problem” because their lack of support or treatment can become a catalyst for unusual behaviours that cause stress and disorder. One of the examples she gave was of a man who filed a grievance against his neighbours, complaining that their young child cried loudly late into the night thereby preventing him from sleeping. When the mediators arrived in an attempt to remedy the dispute, the mother of the child was astounded at the complaint since her baby was in bed and asleep every night by eight o’clock. Susan and her colleague were then faced with the uncomfortable position of trying to decide which story was more likely: that the mother was lying or that the child was in fact asleep by eight o’clock every night and that perhaps the complainant was hearing voices.

Another example involved a man who had been arguing with his neighbour about a broken front gate. Unable to reach an agreement, the case was referred to neighbourhood mediation and a team of practitioners was assembled. The mediation appeared to move along successfully and a resolution had been agreed upon, when suddenly the man turned and said: “Right, so then what are we going to do about that front gate?” as though he had just forgotten or misunderstood the entire conversation. Since he had agreed to a resolution moments before, Susan’s question then became: “What did he agree to?”

These examples point to some of the complexities that restorative justice practitioners must negotiate when working with service users who have mental health issues. Additionally, all three participants pointed out that victims can have mental health

issues as well, not just offenders. Although seemingly not as prevalent as the mental illnesses observed in offenders who took part in the victim-offender mediation project discussed by John, there was no doubt that victims could experience mental health issues as well, most notably symptoms associated with post-traumatic stress disorder (PTSD). Max explained that sometimes the crime itself can induce mental health issues, such as a phobic fear of leaving one's home after an assault or developing a seemingly compulsive desire to check and re-check one's doors and windows to make sure they are locked.

Drug use. Another strong message that came out of all three interviews was that participants observed a link between mental illness and drug use. In fact, there was speculation that some of the mental health issues were drug-induced, or the result of a previous history of drug use. Max said: "There was this one guy who kind of admitted that he'd been having counseling for mental [health] issues that his counselors believe were brought on by his use of crack cocaine". Apparently, the service user's mental health team believed that his drug use "inflated his psychosis", although it is not clear whether there had been a diagnosed mental illnesses to begin with. John's comments also support this observation. He said: "There was definitely a correlation as far as we were concerned between the mental health of the individuals and an admission to drugs, or previous history of drug use".

Lastly Susan stated that that she encountered addiction on a regular basis in her work with neighbourhood mediation, and certainly noticed a connection between drug use and mental health issues. She speculated: "The kind of mental health problem which I think is quite difficult to deal with is addictions." She then gave several examples of

mediations that she had tried to run unsuccessfully due to the service user's state of intoxication.

Shortage of diagnoses. Although John was able to identify schizophrenia, bipolar disorder and severe depression as diagnoses that had been prevalent in his RJ project, all three participants spoke of an overall shortage of formal diagnoses and a more intuitive recognition that an individual may be experiencing mental health issues. They explained that formal diagnostic labels are too often unavailable, especially in a non-judicial RJ process such as neighbourhood mediation, yet practitioners often sense that the individual is behaving in a way that may be considered unusual. As a result, it is possible that RJ practitioners are more attentive to mental health symptoms rather than to diagnostic labels.

Two of the three participants also emphasized the emotional rawness and vulnerability that a restorative justice process brings in and of itself. John described this: "There is so much scope for looking at what's going on in psychological terms in a restorative justice meeting. It's just full of such interesting behaviour that you don't really get a chance to observe in other ways". He explained that individuals often behave in very erratic and unpredictable ways during an RJ process, making it difficult to differentiate between what is a mental illness and what is an extremely emotional response. He clarified: "It can become very difficult to distinguish between a really disturbed emotional state and a mental illness. Sometimes people are emotionally so upset that it could even appear like a mental illness." Consequently John believes that mental health issues are very prevalent, and that RJ practitioners need to be comfortable and competent in working with them.

Competence

The theme of competence was recurring in all three interviews, and presented itself in two forms: service user competence and practitioner competence.

Service user competence. When asked the question of whether service users with serious and persistent mental illness lack that capacity to take part in restorative justice, all three participants responded in the negative. John exclaimed: "If somebody was to say back in...pre-Victorian times 'this woman can't do restorative justice cuz her brain's not big enough'today we'd leap all over that and say that's outrageous. Well it's outrageous with mental health as well!". Susan said: "Rubbish. You could just look up the *Mental Capacity Act* yourself...in there it is defined who has mental capacity for what, and I'm pretty sure it doesn't say that anybody with a mental health issue is deemed incapable." John asserted that service users with mental illness are just as articulate as anyone else, and just as capable of entering into meaningful dialogue. The only requirement that all three participants identified was stability. The service user needed to be stable at the time of the RJ process.

Max and Susan said that competence also depended on the type of mental illness that the service user has. Susan said: "If it's a mental health problem like anxiety or depression....where people are managing their emotions....that's usually perfectly capable with the right support, but if people are in a completely differently world and interpret things in a completely different way...like if somebody's very paranoid...then they (the administrators in her neighbourhood mediation program) would say well, no." The concern appeared to be around communication, a worry that no resolution could be made with such a major difference of opinion regarding the facts of the event.

Max's worry was about safety, an issue that will be discussed below. He explained that as practitioner it is important to him that the individual with the mental illness not be intimidating or frightening to others, especially if the victim is present. However, both Max and Susan agreed that these concerns were mostly put to rest once it was established that the person's mental health was stable.

Another major issue that came up during the discussion on service user competence was the fact that denying individuals RJ on the grounds of their mental illness was not in line with RJ ideology. John pointed out that such actions were disempowering to individuals with mental illness, and took opportunities away from victims and offenders who wanted to either move on from the crime or take responsibility for their actions. Empowerment, he pointed out, is at the very core of restorative justice and is the component that makes restorative justice unique. Consequently, taking such disempowering action and abusing one's position as practitioner in this way would be against RJ values. Max, it seems, would have agreed. He explained that restorative justice is primarily about listening and understanding, and that these aspirations remain the same whether the individuals involved have a mental illness or not. He asserted that the practitioner's role is always to attempt to clarify the facts, and that this process is the same regardless of who is participating.

All three participants also asserted that a good RJ practitioner should look at each case individually. As a result, no group of people should be eliminated right from the start. This would be unethical. Furthermore, John emphasized that denying RJ on such grounds is likely the result of fears and misgivings brought on by stereotypes, such as those

amplified by the media. He said that such statements are based on *assumptions*, and that assumptions, in his experience, are always wrong.

A major issue that arose during conversations about capacity was drug use. All three participants pointed out that drug use indeed contributed to a practitioner's assessment regarding competence. Specific concerns included: memory loss, such as when the service user committed a crime while under the influence, lying in order to hide a drug abuse problem, ambivalence regarding RJ appointments and attending RJ processes while intoxicated. Susan recollected one case where she was forced to stop mediation mid-process because one of the parties was so intoxicated that he was becoming a potential danger to the other individual. She said: "Sometimes people lie to you...sometimes despite however hard you try you arrive and they are stoned or drunk, and you can't really have a meeting when somebody's stoned or drunk". Nonetheless all three practitioners also emphasized that since RJ cases ought to be selected on a case-by-case basis, no individual should be eliminated due to his or her drug use. They simply stressed that drug use brought forth concerns regarding competence more frequently than did serious and persistent mental illness. John also added that even if an offender did not have any recollection of the crime, a successful RJ process would still be possible since it would give the offender an opportunity to explain the causal role that his or her drug use may have played in the event, and what impact it had.

John introduced a concept that he referred to as "cognitive dissonance". He observed that many of the offenders in his victim-offender mediation scheme appeared to have a shallow appreciation of the impact of their crime, psychologically speaking. They struggled to understand the emotional effect that their actions had on their victim(s).

Rather, they tended to focus on the material aspect of the event and sought restitution through means such as offering to return an item that was taken, or repaying money that had been stolen. They were shocked to discover that the victim cared little about the money, but instead has been emotionally traumatized by the event. According to John, it wasn't until these offenders entered into the RJ process that they began learning about the emotional impact of their crime. This instigated a state of confusion and a shift in their worldview. This state of confusion is what John calls "cognitive dissonance", and is the time that he believes real change and healing can happen.

A last finding about service user competence relates to a discussion about the steps that would be taken in order to establish competence if a service user's mental health was in question. John was the only participant to speak at length about this issue, and said that usually such a decision would be left to a psychiatrist. Since RJ practitioners are generally not mental health workers, they are consequently not qualified to make such assessments and should seek out individuals who are, if there are concerns. In the restorative justice project that John had been a part of, four cases had been dismissed on the grounds of serious mental illness. Nevertheless, all four had been dismissed following a recommendation from the service users' psychiatrists, who believed that the RJ process would hinder their treatment and recovery. Importantly however, this decision was made in collaboration with the psychiatrist, the service user and the practitioner. The service users had input into the decision and were given opportunity to discuss their own views. In these four cases, the service users were in agreement with the psychiatrists, and no dispute ensued. Nonetheless, despite his enthusiasm for involving individuals with serious mental health issues in RJ, John also admitted that in case of disagreement between the

service user and the psychiatrist, most practitioners, himself included, would likely side with the psychiatrist. He explained that practitioners have safety and liability matters to attend to, and as a result would most likely err on the side of caution. Being ill experienced in mental health assessment themselves, they would likely desist from taking on such cases. Importantly, he appeared optimistic and said that most psychiatrists were supportive of RJ, as long as the process did not interfere with the patient's treatment or recovery. He did not feel that mental health professionals stood in the way of promoting RJ amongst this population. In fact, he pointed out that such collaboration between the parties appeared optimal for ensuring that everyone felt safe and comfortable.

Additionally, he stressed that the onus should be on the psychiatrist to prove that the individual is unsafe or at risk of decompensating. If the psychiatrist is unable to do so, the practitioner should assume that the person is safe, and carry on with the process.

Practitioner competence. An unexpected finding to emerge from interviews with practitioners showed that of bigger concern than service user competence is *practitioner* competence. Practitioners, it seems, may have some serious trepidations about their ability and skill to effectively manage cases involving individuals with serious mental illness. This may explain, at least in part, the seemingly small number of RJ cases that are being processed with individuals who have serious mental health issues.

First, both John and Max explained that in order to be a good RJ practitioner one must have confidence. This confidence puts service users at ease, and makes them feel that they are being well looked after. Max stressed the importance of this quality by saying that even if one does not feel confident, one must present with confidence. Confidence, in other words, can be forged. Nonetheless, it stands to reason that the most confident RJ

practitioner is one who truly feels secure in his or her ability to run the process successfully. This is likely the most authentic and genuine type of confidence, and the type of confidence that service users feel most at ease with.

Exploring the issue of practitioner competence further, John stressed that along with having confidence, the practitioner must believe in the values of RJ, most notably in empowerment. According to him, RJ practice does not require any formal degree or education, but rather a specific set of beliefs and values that are congruent with the paradigm. He singled out empowerment and spoke about it at length since he believed that empowerment is what makes RJ unique. Empowerment allows the individuals involved in the event to take charge, and consequently begin the journey toward healing. Max also spoke of empowerment, stating that as a practitioner he spends a lot of time trying to look like he is doing nothing at all. The practitioner's main purpose, he said, is to manage safety, while the individuals affected by the crime are given the power to own the rest.

An interesting point of discussion that emerged from the interviews was that confidence in one's ability as a practitioner was directly associated with one's competence as a practitioner. In other words, as confidence in one's ability to manage a successful RJ process grows, so does one's competence as practitioner. Relating this to practice with service users with serious mental illness, John pointed out that having confidence in one's ability to run a RJ process successfully enhances competence in processing cases with this population. Furthermore, these findings suggest that confidence in one's ability to proficiently manage a RJ process with a service user who has a serious mental health issue is directly linked to one's level of comfort with mental illness: the higher the degree of comfort, the higher the confidence and belief in one's competence. Additionally, findings

also suggest that an increased level of comfort with mental illness may be linked to an increased level of personal contact with mental illness. As a result, it is possible that an increased level of personal contact with mental illness enhances one's competence as practitioner when processing RJ cases with service users who have serious and persistent mental illness.

All three practitioners interviewed in this study had had personal contact with individuals with mental illness prior to conducting RJ processes with such persons. Two of the participants felt that their previous experience with mental illness likely increased their level of comfort with it. Susan did not verbalize such a connection, but revealed a personal story that suggested that her personal contact with mental illness might have contributed to her skill in working with this population. All three practitioners said that they felt quite comfortable conducting RJ with individuals with serious mental health issues, although Susan identified several areas of concern, which will be discussed below.

Both John and Max had served as police officers prior to becoming RJ practitioners. Both had regularly encountered individuals with serious mental health issues while at work; however each also shared one particularly transformative experience that appeared fundamental to his understanding and comfort with mental illness.

John had no experience with mental illness at the time of his admission into the police force. As a result, he was advised to attend weekly visits to a local psychiatric hospital throughout the course of his training. He began to socialize with the patients there, and made an effort to engage in conversations with them, inadvertently getting to know them better. Although John admitted that at times he struggled to initiate meaningful conversation, he also said: "I got to the point where I could sit down next to people with

very severe mental disorders and talk to them...”, later adding:” This made it easier for me to communicate with them when I came across them in the streets”. John disclosed that this experience took away his fear of mental illness, and made him much more comfortable and understanding of it.

Max also recalled an incident that occurred early in his career as police officer. While beginning to conduct patrols, he came across a man whose behaviour he found unusual and erratic. He described the man as “quite a strange looking guy...[who] obviously came from a good family, [was] very very well dressed, but just couldn’t control himself”. Although harmless at first, the behaviors appeared increasingly menacing as the days progressed. The man began to smash glasses, throw items at moving vehicles and behave unpredictably. Fearing violence, Max and his colleagues chose to intervene, relocating him to a place of safety. They drove him to a local psychiatric hospital. Max, who knew very little about mental illness at the time, admits that he did not treat this man with a great deal of kindness and compassion. He tearfully recalled laughing at him, poking fun at the man’s unusual behaviour and making him the running joke of the drive. His assumption was that the man was so out of touch with reality that such mockery was acceptable since he didn’t fully understand it anyway.

When the police car finally reached its destination, it was Max who escorted the man out of the police car. Just as the man was getting out of the car, he suddenly turned toward Max, looked him square in the eyes with a clear and lucid gaze, and said: “You know mate, sometimes I wake up. And you laughed at me. I will never forget that”. At that moment Max realized that this man was aware of everything that had happened to him, and was capable of being just as cognizant and in tuned with reality as Max was. It also made Max

realize that this was a real person, an individual who had a mental illness but whose mental state fluctuated. As these thoughts and realizations began coursing through his mind, Max began to feel ashamed. This experience changed him forever. He asserts that he never again treated another person with such disrespect simply because he or she was different. He never again judged another person with mental illness, and alleges that this event inspired him seek out new skills that would better prepare him for working with people who are experiencing mental illness.

Susan's story was about a family member who had struggled with an eating disorder during adolescence. She had witnessed this individual transition from being an exceptionally bright yet under-stimulated and ignored teenager, to an ostracized and feared person with an eating disorder. She said that this family member had been driven out of school because none of the teachers knew how to handle her situation. Susan's observation of the event lead her to believe: "People sort of, you know, distance themselves because they just don't know what to do". Incidentally Susan also revealed that she works in a mental health facility, although was quick to point out that this was simply a coincidence.

In all three cases the personal contact with the individuals with mental illness appeared to enhance the degree of comfort with this population. This degree of comfort, in turn, appeared to enhance the likelihood of processing RJ cases involving service users with serious mental illness. Despite this enthusiasm however, Susan and Max also identified several areas of concern regarding practitioner capacity and skill. Their arguments were very compelling.

Susan's concerns centered on practitioner skill, or rather, a lack thereof. She explained that there is a need for practitioners to learn specific interviewing skills for working with individuals with mental health issues if they hope to become more proficient in this area of practice. The unease, it seems, centers on communication, and knowing "...what to do when you encounter somebody who clearly has a mental health problem". Several of Susan's colleagues shared these apprehensions, and consequently requested that a training session be held on this topic. Unfortunately, the training proved disappointing. The workshop instructor focused on consciousness raising and awareness rather than on teaching actual techniques and skills. Susan believes that it is not necessary for practitioners to know the "length and breadth of the entire mental health system", but rather they need to know "what you do and what you say if....somebody is saying something that clearly doesn't make sense".

Max identified a similar area of concern. He too identified a need for an increase in education on this front, and suggested that awareness training be incorporated into RJ training programs. He added that such training should be conducted by actual individuals who have mental illness, and the skills taught "in a workshop-kind environment where people can turn around and say 'well, what happens to you when you have a psychotic episode? How do we [work] with [other] people with your [mental health] issues, and what do you think we should do?" He argued further than there needs to be a two-way flow of information, "because you don't learn from a national centre for applied learning techniques program; you learn from someone that stands or sits in front of you".

Participants also expressed some criticism of RJ practitioner training programs. Susan believes that practitioners are ill prepared for working with service users who have

mental health issues, and that there is a serious shortage of competence and skill in this area of practice. She pointed out that RJ training programs range from one day to three, with the occasional one that lasts five. Susan, who is an RJ trainer herself, explained that the pressure to keep RJ training sessions short and efficient has made it nearly impossible for practitioners such as her to offer lengthier and more thorough training programs.

When asked about whether she had received any RJ training specific to mental health aside from the workshop mentioned above, the answer was no. Furthermore, she stressed that as a result of these shortcomings, practitioners who feel inept in this area of practice likely dismiss such cases altogether. Max and John supported this outlook, stating that fear and lack of confidence in one's ability to manage such a case skillfully likely contribute to the rejection of cases involving service users with mental health issues.

John and Max shared some of Susan's concerns regarding RJ training. Both criticized it for being too short, too basic and consequently insufficient. When asked specifically about training on mental health, John commented: "The average training does not set out to train them in dealing with mental health". Like Susan, he explained that most RJ training sessions last three days to one week, and tend to focus on the restorative justice process itself, and not on skills. He also explained that these sessions neglect to incorporate a teaching component on victim's needs, let alone the needs of individuals with mental health issues. Max's testimony supported this stance. He himself received zero training on mental health, and attributes his knowledge and skill in this area to personal contact with individuals who have mental illness, and to his years of experience serving as a police officer. Lastly, all three participants said that there were many RJ practitioners in the UK

who had been through training but had little or no experience conducting RJ processes outside of it. As a result, there may be many RJ practitioners who are simply inexperienced.

Safety and Risk

Defining and determining safety. Without doubt one of the major concerns for RJ practitioners is safety. This may be especially true in victim-offender conferences, such as those conducted by John and Max, although it stands to reason that safety is universally important to all RJ practitioners. According to Max, safety encompasses both the physical and emotional wellbeing of all participants. It is not sufficient that participants are kept physically safe, but also that retraumatization and emotional injury are prevented.

Each participant emphasized the importance of safety as well as the need to assess safety before the commencement of any RJ process. Participants explained that they performed safety appraisals prior to accepting a case. These assessments make up one component of the preparation stage, and provide space for the practitioner to establish whether the case is one that he or she can safely manage. One of the major elements of such a safety assessment is the evaluation of risk.

Susan was the only participant to admit that her power in conducting risk assessments was minimal since cases were referred to her through an administrative authority. She said that this caused quite a problem, since it often instigated a situation in which she and her colleagues arrived at mediation ill prepared. She said that they regularly received “poor quality information”, and that this made it particularly difficult to manage safety, especially when working with individuals who were living with addictions. Nonetheless her assessment of risk occurred primarily at the time of mediation, and included elements such as state of sobriety, emotional and physical safety for service users

and mental stability. Additionally, as mentioned previously, Susan has not been not afraid to use her power as practitioner to put an end to proceedings once she feels that an individual's demeanor or behaviour is upsetting to the other party.

John said that he looks at factors such as power imbalance, violence, probability of victim revictimization, and probability of offender persecution. Additionally he acknowledged that conducting risk assessments can be disempowering to service users and should be kept to a minimum. Nonetheless he asserted: "The primary task of a facilitator is safety".

Risk: aversion versus management. Interestingly, despite the emphasis that all participants placed on safety, they also declared that risk can often be managed. John explained: "The issue in all the principles is only about 'is it safe'. And so many people are safe". Consequently, all three participants cautioned against being risk averse. They all felt that their colleagues have become so fearful of risk that practitioners are more likely to reject a case than engage in a RJ process that appears even minimally risky. Susan said that she had one group refuse to role-play a RJ scenario during training because they feared it was too perilous. It was a role-play meant to be challenging, but by no means too risky to undertake. Relating this to mental illness, all three participants agreed that practitioners who feel incompetent working with service users who have mental health issues are likely to appraise the risk of taking on such a case as too high, and subsequently reject it. Fortunately, participants in this study identified several methods that could be used to minimize any risk specific to service users with mental illness.

First, both John and Susan identified support persons as a good resource. Specifically, both recalled RJ cases they had processed where the service users with mental

illness or addictions had invited their mental health or addictions workers to the RJ conference. This proved very successful. Other support persons that John and Susan spoke of included family members and friends. The common theme appeared to be the presence of people who would provide emotional support and understanding.

A second resource that John identified was partnership with psychiatrists. He said that he collaborated extensively with psychiatrists throughout his work on the RJ project, and that psychiatrists were a good resource for information. They provided practitioners with education about mental illness, and were able to relay information to practitioners as well as to patients. Just as psychiatrists were available to educate practitioners, they were also a good resource for informing service users about RJ and preparing them for the upcoming proceedings.

Yet another method for reducing risk that all three participants spoke of was the acquisition of information. Specifically, participants emphasized the importance of practitioners being sufficiently informed. This was important for a number of reasons, primarily because an informed practitioner could pass information on to service users during the preparatory stage of the process. Max explained: "If we have the full facts, then I can give the full facts [to the service users]". He also said that having such information provides an opportunity for practitioners to discuss any potential risks. John recalled a case in which the service user who had a mental illness behaved in a way that could be interpreted as intimidating, even though it was actually harmless and safe. John explained: "We handled that by just telling the victim what the guy did. And then it became less of an issue. I mean, yes, it was intimidating, but we were able to say 'this is how he behaved in our preparatory interview, we found it a little bit uncomfortable at certain times, and you

may find it uncomfortable too, so do you still want to meet the guy?" In so doing, the practitioner was able to ensure the other party that the individual was safe, and that his or her unusual behaviour was nothing to be afraid of. It becomes a matter of knowing what to expect, and knowing what is expected. Max and John both said that as long as all service users are prepared, aware and comfortable with entering into the RJ process, there is "absolutely no problem".

Susan also discussed the benefits that come with being informed, and the risk management that she can consequently do once she has all the right information. For example, she explained that when she knows that a person has an addiction, she is able to have a conversation with that individual about needs and supports, and ask them to come to the mediation sober, if possible. It also gives her the opportunity to prepare the room in a specific way, in order to accommodate that person's needs and comforts. For example, she often seats heavy smokers next to windows and doors, allowing them space and opportunity to leave if they feel that they are struggling with abstinence during the mediation. She says that these small gestures enhance the likelihood that the individual will participate and see the process through to completion.

Participants also spoke of confidence as a factor that increased one's willingness to run a "risky" RJ case: more specifically, confidence in one's ability to manage such a case safely. Such confidence, it would seem, appears associated yet again with one's competence as practitioner, and one's comfort with mental illness. Having increased confidence in one's ability to manage a RJ case with an individual who has mental illness appears to be associated with a belief in one's competence to do so. It stands to reason that a practitioner who feels both confident and competent would be more willing to take on

risk, or perceive the situation as less risky than a practitioner who does not have such confidence, competence and experience. John commented: “There are so many benefits to the process. Nobody wants to do wrong, but there are so many benefits that if we just decline to do it, on the slightest probability of risk, then we would be doing victims and offenders in many cases a disservice”. Susan ended the discussion on risk by saying that rather than focusing on the question: “What is the risk of processing this RJ case”, it is equally important for practitioners to ask: “What is the risk of not doing it”.

Stigma and the Normalization of Mental Illness

Findings suggest that there may be a connection between restorative justice and combating stigma. This connection appears to exist on two levels.

Personal contact and education as tools for increasing use of RJ. First, it may be possible that increasing personal contact with individuals who have mental illness enhances the competence of practitioners, and in so doing augments the usage of RJ with this population. All three participants appeared to have a reasonably good understanding of mental illness, however more importantly; they all had an understanding that came from a place of compassion and empathy. This understanding may be directly linked to stories of personal contact with individuals who have mental illness. One might argue that interviewees experienced a reduction in stigma as an outcome of their personal experience. Hence, it was not surprising that when participants were asked if they thought that including mental health training and increasingly personal contact with individuals who have mental illness would increase the likelihood of practitioners processing RJ cases with this population, all responded in the affirmative. Their experiences, it would seem, reduced their fear and apprehension to a point where they became able to comfortably work with

service users who have mental illness, despite certain trepidations and concerns, such as those emphasized by Susan and Max.

John was very vocal on this issue and agreed that personal contact was a very effective way of reducing stigma. He also agreed that exposing practitioners to personal contact with individuals with mental illness, such as through volunteering at mental health centers, would be beneficial for conducting RJ with this population, since it would presumably increase levels of comfort, and consequently prevent the overstatement of risk. Similarly Max emphasized the importance of RJ practitioners having an “appropriate level of awareness”, since his own experience opened his eyes and humanized mental illness in a way that would not have happened otherwise. He argued that if practitioners were to become more experienced with mental health, it would initiate greater access to RJ for individuals with mental illness. He referred to the stigma that exists amongst practitioners as the “spider syndrome”, explaining: “We’re scared of spiders because we don’t know enough about them. We’re scared of mental illness because we don’t know enough about it”. He consequently argued that if one enhances one’s understanding and knowledge, one decreases one’s fear and consequently enhances the use of RJ with this population.

RJ as a stigma-reducing tool. Another major premise that came out these interviews was the idea that the RJ process itself can be used as a stigma-reducing tool. It can initiate conversation about mental illness, and promote opportunity for all persons involved in the RJ process to learn about mental illness from the service user who is experiencing it.

About this topic, John said: “RJ is the exposure”. He was speaking broadly, explaining that RJ provides an opportunity for offenders to meet victims, and vice versa. In

his experience, such meetings often generate shifts in ways of thinking, and increase levels of understanding for the parties involved. Although John made it clear that accountability and forgiveness were not a requirement of any RJ process that he had worked on, he wanted to emphasize the power that such meetings can have for producing a deeper consideration of people's emotions, behaviours and perspectives. As a result, he agreed that it could be a powerful combatant of stigma against mental illness.

John also explained that RJ conferences involving individuals with mental illness create a platform for service users who have mental illness to educate others about their condition, in a safe and non-judgmental environment. At the same time, it gives an opportunity for the service users who do not have a mental illness to ask questions and learn about mental illness, and perhaps leave the conference with less stigmatizing thoughts. He gives the following examples to support his point: "If the victim was to hear from a second hand source that the offender had schizophrenia, they would be very likely to have a very negative idea of what that is, probably lump this offender in with all the other bad news stories about schizophrenics....and be really frightened....whereas I think that...when they meet...the victim finds out, in many cases, quite a lot of technical information about what it means". He then admitted that he personally learned more about what it is like to live with schizophrenia from conferences such as these than he could have from any other source, and that the service users likely did too. Additionally, John explained that he is an advocate for face-to-face RJ, instead of RJ conducted via letter correspondence. He argued that the latter is generally much less impactful. Personal contact therefore, appears vital.

Max supported this view, stating that RJ processes could fight stigma, because they could provide an opportunity for learning and increasing understanding. He said: “In general, I personally believe that most people with mental health problems or mental illness just want to be treated normally and shown a bit of understanding”. RJ, he argued, is a good conduit for such opportunities and conversations. However, despite his enthusiasm, Max also stressed that RJ does not have the power to reduce stigma on a large scale, since RJ conferences and mediations are private affairs. He then jokingly added that the only way to augment this would be to video a successful RJ conference with a person with mental illness, and play it on primetime television.

RJ and the normalization of mental illness. Another theme that emerged from the interviews was one of RJ being a tool for the normalization of mental illness. Related to combating stigma, normalization of mental health issues is the process by which the line between “us” and “other” becomes diminished, and there is recognition that all people can develop mental health issues. Consequently, individuals with mental illness ought not to be ostracized. Participants alluded to such a phenomenon by making comments about the high prevalence of mental health issues, and drawing attention to the observation that even one single event, such as a crime, could alter a person’s psychological state. More specifically, participants spoke of high rates of symptoms of post-traumatic stress disorder that they have observed in victims of crime. Max explained: “Well mental health, correct me if I’m wrong, but if something happens to you, it can alter...you know I can walk out this door and a big monster can go “BAAA!”, and I may never walk out that door ever again.” He then explained that he has observed such fears and phobias diminish following RJ processes.

Susan also spoke of the benefits that RJ appeared to have for individuals suffering from symptoms of PTSD. Additionally, she explained: "It varies a great deal what counts as a mental health problem", saying that a few people she has worked with had a diagnosed serious and persistent mental illness, although their mental illness was unnoticeable. These individuals had to specifically disclose that they had a mental illness, because their behaviours would not dictate that there was anything different about them. They were quite possibly stable and in recovery. On the other hand Susan also spoke of an individual she worked with who asked strange questions and displayed trouble communicating. In this case, Susan said that the symptoms of the mental illness were much more obvious and pervasive. Her argument was that mental illness is highly variable, and what counts as a "mentally ill" individual is rarely black and white, since individuals with serious and persistent mental illness can behave in ways that seem entirely within the range of what would be considered normal.

John spoke of mental illness as a continuum. He explained that most individuals likely sit somewhere along a mental health continuum, and that the defining factor of what should be considered a mental illness is very vague. He defended this claim by arguing that most people's behaviours fluctuate throughout their lives, explaining further that the singling out of persons with mental illness "assumes that a lot of mental disorders are switches." He believes that there exists an assumption that individuals with mental illness " ...are either mentally ill or they are not. They either have schizophrenia or they have not. They are depressed or they are not. And it's not like that." In addition, John also spoke of the benefits that RJ brings to individuals who have a diagnosed mental illness, in encouraging them to accept their condition without shame. He explained that often service

users with mental illness are able to use the RJ process to explain their mental illness to another person, and in so doing, discuss their symptoms in a safe environment where they are not judged. According to John, this bears fruitful outcomes for service users who have a mental illness, because they are given opportunity to explain that they are the same as anyone else, except they live with symptoms x, y or z. John also explained that conversations such as these go a long way toward generating empathy for the person with the mental illness, and can occasionally produce outcome agreements that are conducive to recovery. For example, he explained that it is common for RJ outcome agreements to include medication management and connection with a mental health worker, as means of preventing a recurrence of the crime.

As mentioned previously, John also said that the behaviours of many victims might be considered unusual and exaggerated. He said that he has witnessed victims cry and scream erratically during RJ conferences, behaving in ways that may seem embellished and bizarre. He regularly wonders if such behaviours are an appropriate emotional response to the event, or concrete signs of mental illness. He eventually shared that his experiences have led him to believe that the line between these two categories is very fine, and that any emotional response, even if outside the range of what would be considered normal, is not necessarily indicative of mental illness. The individual may simply be expressing his or her emotions in an expected and reasonable fashion. This is their right. Consequently, John said that the boundaries of what constitutes a mental illness have become less important to him, and he has learned to simply focus on ensuring safety and managing behaviours, whatever they might be, without searching for existing diagnoses.

To specialize, or not to specialize. Lastly, all three participants argued that it is favourable that all RJ practitioners become more skilled in mental health than to have selective practitioners who specialize in it. Their argument stemmed from the fact that all three strongly believed in a high prevalence of mental illness amongst service users. Additionally, participants emphasized that most mental illness is likely undiagnosed and that the definition of what constitutes mental illness remains very vague. Consequently, participants stood behind the claim that all RJ practitioners ought to become competent and comfortable with mental health and symptoms of mental illness. That is not to say that RJ practitioners ought to become mental health professionals. Rather, they ought to increase their skills to a point where their levels of comfort become enhanced, and thoughts of stigma and stereotype decreased. Specific skills and knowledge that are lacking can become enhanced through collaboration with mental health professionals, and an overall increase in mental health literacy. All three participants strongly believed that work with service users who have mental illness should be universal amongst RJ practitioners, rather than specialized.

Conclusion

Personal Contact and Mental Health Education

The findings in this study provide important insights into restorative justice practitioner development, and support the conclusions of previous research that exists in the literature (Brown et al., 2010; Eisenberg et al., 2012; Gould et al., 2007; Norman et al., 2008; Reavley & Jorm, 2011; Sadler et al., 2012; Scheyett, 2005). Most notable is the observation that all study participants experienced personal contact with individuals with mental illness, which likely contributed to their enhanced comfort with mental illness and decrease in stigmatizing thoughts and behaviours. Furthermore, all participants had either initiated personal education about mental illness, such as through conversations with psychiatrists or service users, or requested more training opportunities from their RJ program coordinators and trainers. Consequently, personal contact and education may have instigated willingness to practice RJ with service users who have mental illness. This supports previous research by Brown et al. (2010), Eisenberg et al. (2012), Gould et al. (2007), Norman et al. (2008) and Scheyett (2005) which suggests that personal contact combined with education are most effective in reducing stigma.

Changing Attitudes

Findings also support the notion that attitudes about mental illness are changing. First, it is interesting to note that participants largely accepted and normalized symptoms related to PTSD, especially when discussing victims of crime. Participants widely accepted that victims of crime are likely to be emotionally impacted, and consequently likely to experience increased stress, anxiety and emotional distress. This supports findings from Project Liberty, the TRiM Program and the study by Reavley and Jorm (2011), which

suggest an increased acceptance of symptoms of PTSD in the general public, and a growing appreciation for the emotional impact of trauma.

Second, findings also point to the existence of a hierarchy of mental illnesses, in which certain mental illness such as PTSD, depression or anxiety disorders are breaking through stigma walls while others such as schizophrenia are not. Although participants were strongly supportive of including individuals with mental illness in RJ conferences, they also articulated some concerns about working with service users who were under the influence of drugs or living with a mental illness that imperiled their connection with reality. This too supports previous research by Norman et al. (2008), Reavley and Jorm (2011) and Sadler et al. (2012), which showed that attitudes about mental illness differed depending on the diagnosis. However, it is important to note that participants articulated communication as a barrier, not stigma, and so it remains unclear whether individuals with thought disorders are limited due to stigma and stereotype or because there is some legitimate concern over their ability to fully participate in a RJ conference.

Continuing Dominance of the Biomedical Model

Third, findings also demonstrate the continuing dominance of the medical community over matters of mental health and mental illness, supporting Fee (2000) and Estroff et al.'s (1991) claim. This is evident in the importance placed on the opinions of psychiatrists with regards to the mental status of patients, and the unquestionable acceptance of psychiatrists as experts on mental health. It is also evident in the language that participants used during interviews: the instinctive use of diagnostic labels. However, it must be said that despite this, participants also admitted that they tried to empower service users as much as possible, and consequently placed great importance on the voices of individuals with

mental illness, putting the onus on psychiatrists to prove that service users were unsafe to take part in RJ. This is in line with PSR ideology, and perhaps points to an ideological similarity between these two subject areas. Furthermore, participants also said that they placed greater importance on behaviours rather than on diagnostic labels, since labels were often unavailable and relatively unimportant in an RJ conference. Participants were also quick to emphasize that diagnoses and definitions of abnormal behaviour were rarely black and white, and that consequently, participants conceptualized mental health as continuum or spectrum, embracing many shades of grey. As a result, it seems likely that the latest edition of the DSM would substantiate such a worldview, and support participants' observations.

The Social Environment and Definitions of Normal and Abnormal Behaviour

This last point raises an interesting discussion on the interplay between social environment and definitions of what constitutes normal and abnormal behaviour, as discussed by Davison et al. (2004), Foucault (1965), Passer and Smith (2001), Pescolido and Rubin (2000) and Scull (1977). Interestingly, all three participants largely accepted a certain normalization of mental illness and spoke in depth about the diversity of behaviour that RJ conferences generate. More specifically, participants, John especially, discussed the emotional rawness of RJ conferences, and the unpredictable and highly emotive behavioural outbursts that often emerge from service users. This was the main force behind the recommendation that all RJ practitioners be trained in mental health, rather than have such services specialized. The consensus was that exaggerated, eccentric and perhaps unusual behaviour is so prevalent and likely to occur in an RJ process that all practitioners need to be comfortable working with it. The term 'abnormal behaviour', it

would seem, has little meaning and definition, and consequently, such behaviour may in fact be accepted as the norm within RJ, if not outside of it. Connecting this with the literature, it would seem that definitions of mental illness have become blurred because the social environment is such that behaviours deemed abnormal outside of RJ are perfectly normal within in. Furthermore, considering the observation that mental health diagnoses are seemingly rare, these practitioners accept that a wide diversity of behaviour is in fact, the norm. The only concern for processing RJ with individuals who have serious and persistent mental illness then becomes safety and communication, and the only hindrance, fear and stigma.

Stability Defined

The issue of safety and communication appears to be linked with the requirement that individuals who wish to take part in RJ be stable. One could argue that despite wanting to have more knowledge about mental illness, practitioners interviewed for this study cared little for diagnostic labels and were more concerned with behaviours. However, it is not surprising that they would identify communication as a main factor in determining stability. Since RJ conferences are generally about conversation and dialogue, communication becomes a key component to success. Similar is the stance behind attachment to reality, and the argument that RJ cannot be conducted if there is disagreement about the facts about reality. Consequently, findings suggest that communication, along with presence of mind, are the key factors affiliated with stability. This may be why individuals with thought disorders, as well as those under the influence of drugs, are not seen fit to take part in RJ until such a time that they are able to communicate and be present.

Implications for Social Work, Mental Health and Restorative Justice Practice

The implications of these findings for restorative justice practice may be significant. Findings may demonstrate a need for increased mental health training, and point to a recommendation for promoting personal contact with individuals with mental illness amongst restorative justice practitioners. All participants spoke of a major shortage of mental health training, and the subsequent omission of preparation for working with mental health issues. Since participants articulated a high prevalence of mental health issues in RJ proceedings, this finding is significant and points to a gap in training.

Noteworthy is the discussion brought forth by John, who spoke of incorporating personal contact with mental illness into RJ training programs. He specifically emphasized the transformative power that such exposure might bring to RJ, and supported Susan's stance that consciousness raising and basic mental health training are not enough. Perhaps RJ programs should consider asking trainees to volunteer at mental health centers or clubhouses in order to become more comfortable with mental illness. Combined with basic mental health education and skill enhancement, this could be a recipe for increasingly RJ work with this population. Lastly, findings may also demonstrate a certain level of incompetence for working with individuals with mental health issues amongst newly trained RJ practitioners, stemming from a tendency for inadequately short training programs.

The discourse on training is associated with the normalization of mental illness. If we take the stance that behaviours teetering on abnormal outside of RJ are in fact normal within it, then increasing comfort with working with such behaviours is a necessary step toward improving practitioner competence. Furthermore, the argument can be made that

such an initiative could generate major opportunity for including individuals with serious mental illness in RJ processes, and in-so-doing, be imperative to promoting social justice and inclusionary citizenship.

One of the other major implications of this research is the notion that RJ can be used as a stigma-fighting tool. If personal contact and education are central components for stigma reduction, then again, RJ presents a great opportunity. Through RJ, discourse about mental illness is likely to develop, generating occasion for the behaviours to be understood and the individuals humanized. In other words, the boundaries between “us” and “other” can be pushed through RJ, and consequently, promote the inclusion and normalization of mental illness within our society. Since it has been established that in order to participate in RJ service users must be stable, which is defined as being able to communicate and be mentally present throughout the process, safety can be ensured, and meaningful dialogue about mental illness can ensue. The only necessity for this is that the practitioner feels confident, competent and comfortable working with mental health issues, and consequently be able to maintain safety.

There are also major implications for social work, and for the promotion of increased involvement in RJ. Social work defines itself through social justice. It is a profession grounded on the pursuit of social justice, founded on advocacy and a belief in client self-determination and autonomy. RJ therefore, is a paradigm that intertwines social work ideology, and shares values such as promotion of service user autonomy, self-determination, empowerment and shifts in power. It also inspires hope and healing. As a result, the argument can be made that social work, as a profession, has an obligation to become more involved in RJ practice if it wants to uphold its values and participate in

social action. Contributing to this stance is the proposition that RJ can be used as a stigma-fighting tool. Not only does RJ have the power to diminish stigma in practitioners, and in so doing promote greater inclusion, but it may also have the power to combat stigma through the processes and conferences themselves. If we consider that restorative justice itself can be a tool for decreasing stigma, then we can argue that restorative justice can become part of a social justice movement. With its professional emphasis on pursuing social justice, it would seem that social work ought to secure a place in such an initiative and perhaps become more involved than it has been thus far. Facilitating RJ processes with individuals who have serious and persistent mental illness could decrease stigma, and more importantly, contribute to the elimination of traditional stereotypes. Discourse about mental illness could provide learning and education for those who do not have a current mental illness, and perhaps if not normalize mental illness, enhance opportunities for social inclusion through compassion and dialogue. Like the participant Max said, RJ conferences are private affairs and as such may limit the opportunities for wide scale stigma reduction. Nonetheless change at the micro-level can be powerful, and perhaps, produce a ripple effect that encompasses a wider range of people. After all, stigma research supports the notion that combating stigma is most effective at the individual level, and consequently, is reliant on personal experience and a *micro* journey.

The study's findings may also yield significant implications for social work and mental health. One could suggest that social workers with a background in mental health would be an especially qualified pool from which to recruit RJ practitioners. These professionals would likely have the education and personal experience needed to become

confident RJ practitioners, comfortable working with mental health issues and familiar with the concept of empowerment.

The idea that restorative justice can be a powerful tool for decreasing stigma is particularly important and has implications not only for social work and RJ, but also for mental health. These findings suggest that RJ ideology is in line with PSR ideology, and consequently fits into present best-practice techniques in mental health. This suggests that there is ample room for RJ to enter into partnership with mental health services. If we consider what participants said about inter-professional partnerships, then it stands to reason that a partnership between restorative justice, social work and mental health services could be optimal for mental health advocacy. It is, after all, stigma that appears to be a major factor in limiting access to restorative justice services for individuals with SPMI. It is therefore stigma that needs to be eradicated if we want to see an increase in access to such services for this population.

The above is especially significant if we consider the prevalence of individuals with mental illness in the criminal justice system, both in the UK and in Canada (Mental Health Commission of Canada, 2012). According to John, the vast majority of service users with whom he has worked with in the criminal justice system had a mental illness. Evidently this is a pressing social issue in both countries, and a RJ-mental health-social work team could provide one possible voice of advocacy. It stands to reason that each group is presently dealing with the same social issues and challenges. Consequently, it would seem sensible for these three groups to join forces and collaborate. Furthermore, RJ also has the potential to increase support for individuals with mental illness who are living independently in community. Through initiatives such as neighbourhood mediation, there

is potential for awareness to grow and neighbourly support to increase. This involvement with community could be a key strategy in addressing stigma reduction and change at the community level, a shortage of which has also been linked with the overrepresentation of individuals with mental illness in the criminal justice system (Mental Health Commission of Canada, 2012).

Limitations and Areas for Future Research

This study has several major limitations. First, although qualitative research does not require a large sample size, it would have been interesting to investigate this topic with a larger group, given the common themes that emerged from the interviews. Furthermore, all three participants eagerly provided recommendations for improving RJ practice with individuals who have mental illness. They also gave several suggestions for improving practitioner development. This is important and insightful information and could be pivotal in altering and improving RJ training and practice. Running interviews with a larger sample size could have generated a more rich collection of recommendations from practitioners, and perhaps provided more specific guidance for improvement. This may be an avenue for future research, as would be running focus groups in order to generate more plentiful data on this specific topic.

Second, this study failed in its attempt to reach service users. Consequently, their voices are not present in this research, and data represent only the voices of practitioners. Given the ideological shift within the mental health community with regards to amplifying client voices, neglecting the perspectives and recommendations of service users with mental illness is a major weakness. Any future research should incorporate such voices; however it must be said that this study's omission on this front was not for lack of trying. It

appears that usage of RJ with individuals with serious mental illness is so rare that participants are very difficult to locate, and even more difficult to recruit for research. As a result, it is likely that their voices will remain hushed until practice of RJ amongst this population becomes more prevalent. Still, a study using participatory action research and a transformative framework could yield especially promising insights.

Another limitation of this study is the exclusion of participants from the forensic and criminal justice agencies. These agencies were excluded from recruitment due to logistical constraints. These included strict inter-agency guidelines regarding research, as well as time-limitations for obtaining ethical approval. These agencies have their own ethics boards, and rarely allow small research studies such as mine to conduct research with their clients. The exclusion of participants from these areas is very limiting. Clients from these agencies have a greater likelihood of being part of a restorative justice process since they have committed a crime. In addition, since restorative justice has been put forward as a possible means of reducing the over-representation of individuals with mental illness in the criminal justice system (Mental Health Commission of Canada, 2012), interviewing participants who are presently involved with the criminal justice system could have generated important insights and recommendations.

One element that was highlighted in the interviews but received little mention in the literature was that of the apparent connection between serious and persistent mental illness and drug use. Aside from a brief acknowledgement of drug-induced psychosis resulting from chronic use of amphetamines (Kapur, 2003), this angle had not been explored during the literature review yet appears especially significant for this topic of

interest. This may be one important area of consideration for future research on this subject matter.

Although innovative research can be both exciting and inventive, the absence of previous research can present certain drawbacks. Without previous research, new concepts have to be defined for the first time, and the possibility of expert checking amongst other researchers becomes nil. As a result, the concepts and recommendations in this study are exclusively subject to the interpretation of participants and myself. There are no previous data available for comparison.

Lastly this study was conducted in two countries with differing criminal justice and social service systems. Little attention was paid to acknowledging and describing these differences. The absence of Canadian participants curtailed the ability to generate implications for RJ and social work development in Canada. It is likely that the experiences of RJ practitioners in Canada could be significantly different, and this is an avenue for future research. A comparative study could yield important insights that were not captured by this small-scale research project.

Concluding Remarks

As seen in this thesis, restorative justice and mental health are highly compatible fields of social work practice. This study's findings suggest that collaboration between these three areas would be optimal for creating a strong voice of advocacy and opposition in the fight against stigma. With its emphasis on social justice, social work ought to become increasingly committed to RJ practice, especially given evidence that RJ can be a powerful stigma-fighting tool. By entering into partnership with one another, RJ and social work could find themselves at the forefront of social change, and become increasingly embedded

in the PSR movement that is taking place in the mental health community. In a time where individuals with mental illness are taking back their voice and beginning to feel empowered, to bypass such an opportunity would undermine, if not hinder, social work's devotion to the pursuit of social justice.

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