International Journal of Law and Psychiatry 73 (2020) 101630

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy

Contact between victims and offenders in forensic mental health settings: An exploratory study

Mariëtte van Denderen[a,*], Nienke Verstegen[b], Vivienne de Vogel[b,c], Leida Feringa[a,†]

[a] Forensic Psychiatric Centre Dr. S. van Mesdagclinic, Groningen, the Netherlands
[b] Forensic Psychiatric Centre Van der Hoevenclinic, Utrecht, the Netherlands
[c] University of Applied Sciences Utrecht, the Netherlands

ARTICLE INFO

Keywords:
Victim-offender contact
Restorative justice
Forensic mental health
Victims
Mentally disordered offenders
Mediation

ABSTRACT

Victim-offender contact has been studied extensively in prisons, but research on contact between victims and mentally disordered offenders in forensic mental health settings is lacking. Therefore, an exploratory study was conducted on contact between victims and offenders in four Dutch forensic psychiatric hospitals. These offenders have committed serious (sexually) violent offenses, for which they could not be held fully responsible due to severe psychopathology. During the mandatory treatment, it is possible for offenders and their victims to engage in contact with each other if both parties agree to this. To explore the conditions under which this contact is suitable, we interviewed 35 social workers about their experiences in 57 cases from four Dutch forensic psychiatric hospitals. Findings demonstrated that, according to the social workers, no type of offense or psychopathology were obvious exclusion criteria for victim-offender contact. Social workers described offenders' problem awareness, stable psychiatric condition, and ability to keep to agreements as important factors that enable victim-offender contact. Implications and suggestions for future research are provided.

1. Victim-Offender contact in forensic mental health settings. an exploratory study

Dutch forensic psychiatric hopitals treat people who have committed a serious offense, such as sexual offenses, (attempted) homicide, assault or other violent crimes. These offenders cannot be held fully responsible for their offense because of severe psychopathology. They were found to suffer from DSM-5 diagnoses, such as personality disorders, schizophrenia and other psychotic disorders, developmental disorders, or anxiety and mood disorders (American Psychiatric Association, 2013). Moreover, they are judged to be at high risk for re-offending and therefore sentenced to mandatory treatment. The main aim of forensic treatment is to protect society by treating offenders' risk factors in order to reduce the risk of recidivism.

By committing their offenses, forensic psychiatric patients have caused mental, emotional, financial or physical harm, or a combination of those, to their victims. Lately, there is growing interest in prisons, and more recently also in forensic psychiatric hospitals, in bringing victims and offenders in contact with each other (Drennan & Cooper, 2018; Power, 2017). The growing interest in victim-offender contact, scientifically as well as in clinical practice, fits into more general developments in Restorative Justice (RJ) practices. RJ is an approach to crime which gives victims, offenders, and others involved more influence in the way the consequences of the offense are dealt with (Latimer, Dowden, & Muise, 2005; Sherman, Strang, Mayo-Wilson, Woods, & Ariel, 2015). The focus is less on retribution and deterrence and more on possibilities to involve and meet the needs of victims and offenders (Robinson & Shapland, 2008). RJ practices are viewed as a means of achieving moral, psychological, and social repair (Zinsstag & Keenan, 2017).

Empirical findings on the effects of victim-offender contact in prison populations are not exclusively positive. Some studies report positive effects, such as decreased anger, need for revenge, and PTSD symptoms among victims after contact with their offender (Angel et al., 2014; Daly, 2003). However, other studies report that some victims felt more fearful or worse after meeting the offender (Wemmers & Cyr, 2005). With respect to the few studies about the impact of victim-offender contact on recidivism, some studies found positive effects, while other studies did not find an effect on recidivism (Jonas-van Dijk, Zebel, Claessen, & Nelen, 2019; Livingstone, Macdonald, & Carr, 2013).

The procedures and possible benefits of victim-offender contact, or more broadly RJ practices, have often been studied pre-sentence as an

* Corresponding author at: Research Departement, FPC Dr. S. van Mesdag, Helperlinie 2, 9722 AZ, Groningen, the Netherlands.
E-mail addresses: m.van.denderen@fpcvanmesdag.nl (M. van Denderen), nverstegen@dfzs.nl (N. Verstegen), vdevogel@hoevenkliniek.nl (V. de Vogel).
† Passed away in December 2019.

https://doi.org/10.1016/j.ijlp.2020.101630
Received 15 April 2020; Received in revised form 7 August 2020; Accepted 7 September 2020

addition to criminal prosecution, or in prison populations (Latimer et al., 2005; Sherman et al., 2015; Stewart et al., 2018; Strang et al., 2006; Wemmers & Cyr, 2005; Zebel, Schreurs, & Ufkes, 2017). More recently, such practices have also been employed to varying degrees in forensic mental health hospitals in Australia, Great Britain and the Netherlands (Drennan & Cooper, 2018; Power, 2017; van Denderen, Verstegen, de Vogel, & Feringa, 2019). However, empirical research into these practices in forensic psychiatric hospitals is lacking (Drennan, Cook, & Kiernan, 2015; Garner & Hafemeister, 2003; Hafemeister, Garner, & Bath, 2012; Thomas, Bilger, Wilson, & Draine, 2018). Moreover, few references are made to clinical experience with these practices in the forensic psychiatric population (Hafemeister et al., 2012; Sampers, Bataillie, Dufrainig, & Marchal, 2008). To our current knowledge, there is only one empirical study about the clinical relevance of RJ practices with mentally disordered offenders residing in a forensic mental health setting (Cook, Drennan, & Callanan, 2015). In this study, the authors examined ten cases, by interviewing two victims, two offenders, and eight professionals who facilitated the meeting. Of these ten cases, two resulted in face-to-face contact (these cases concerned violent incidents from offenders to staff members within the hospital). The interviews yielded some indications of positive effects. A victim who initially described feeling 'helpless' said that he began to feel 'less of a victim' (Cook et al., 2015, p. 520). Staff members indicated that the meeting did not only appeal to their personal values, but also had a good fit with therapeutic goals such as offenders taking responsibility for their actions (Cook et al., 2015).

Taken together, empirical data about contact between victims and offenders with a mental disorder is scarce (Hafemeister et al., 2012; Thomas et al., 2018). There is insufficient knowledge about the circumstances under which it could be beneficial for both victims and offenders to have contact with each other, the way these decisions are made, and whether there are specific offender characteristics that influence the decision process. The cases of victim-offender contact examined in the present paper are not limited to repair or the communication of ethical values, but could have a number of aims. These aims vary from restoration of contact as a goal in itself (for example, when victim and offender are relatives), to providing answers to questions victims might have, making agreements about where an offender might go during leave, and addressing the emotional harm of the victim. As such, these cases are not strictly examples of RJ practices, but do fit into the recent development of bringing victims and offenders together with the aim of repairing damage.

1.1. The present study

In the present study, we explored the experiences of social workers with victim-offender contact in four Dutch forensic psychiatric hospitals. The goal of this study was to gain insight into the procedure and ways of decision making in victim-offender contact in forensic mental health practice. The following research questions will be addressed:

(1) Who initiated contact between victim and offender, for what reason, what was the type of contact, and how did contact benefit the victim and offender?
(2) Which offender characteristics are considered important in (making decisions about) contact with victims?
(3) How were any impeding factors accounted for in practice?

The results of this study may be useful for practitioners in forensic hospitals when they have to make choices about victim-offender contact in their services.

2. Method

2.1. Setting and participants

The study was conducted in one medium secure and three high secure forensic psychiatric hospitals in the Netherlands.[1] In Dutch forensic psychiatric hospitals, offenders are treated under a court imposed hospital order (The Dutch entrustment act called Terbeschikkingstelling (TBS), translated literally as "at the discretion of the state") (van Marle, 2002). The court may impose the TBS-order on offenders who have committed a serious violent offense, are considered to be at high risk for re-offending and who have diminished responsibility for their offense because of severe psychopathology. In most cases, offenders reside in prison for several years prior to their stay in the forensic hospital. Offenders reside in forensic hospitals as long as the court deems it necessary to adequately treat the offender and reduce the risk of recidivism, based on advice from treatment evaluations and structured risk assessments (van Marle, 2002). Treatment endeavours in forensic psychiatric hospitals are aimed at preventing re-offending and a safe return to society.

All offenders included in the present study are adults who have committed severe offenses such as sexual offenses, severe violence and (attempted) homicide. Prior to their conviction, offenders have undergone extensive psychopathological assessment by a multidisciplinary team of psychologists and psychiatrists, often in the Observation Clinic of the Ministry of Justice (Pieter Baan Center), where mental disorders are diagnosed using the criteria of the DSM-5 (American Psychiatric Association, 2013). In the hospitals where these offenders were subsequently admitted for treatment, diagnoses were reassessed carefully by file investigation and supplemented with standardized questionnaires, interviews or personality tests.

2.2. Victim-offender contact in this study

In the current study, victims are defined as persons who have experienced a crime, or who have lost a loved one through murder or homicide. Contact between a victim and an offender with a mental disorder could be face-to-face, by letter, by phone, or via a neutral third person, under guidance of a social worker of the hospital or a mediator of a neutral organization. Contact might vary from one meeting to multiple meetings. Contact is aimed at fulfilling the needs of both victim and offender, is always voluntary and can be ended at any time on request of one of the involved parties. The procedures necessary to carry out victim-offender contact are executed by social workers of the hospital or by mediators of an independent organization.[2] The primary task of social workers in forensic hospitals is to establish contact with the social network of the offenders and involve them, where possible, in the offenders' treatment with the goal of establishing a prosocial and supportive network for the offender. The social worker or mediator makes an inventory of the wishes and expectations of the victim and offender separately. Decisions about how to proceed (in terms of establishing contact or not and if yes, what type of contact) are made by the treatment supervisor and the social worker. Contact may be initiated by the offender, the victim or by the social worker. In the latter case, social workers may initiate victim-offender-contact because they consider it to be important that both parties meet and make agreements with each other. This is especially important when victim and offender are relatives and it is likely that they will see each other after the offender is discharged from the psychiatric hospital. Since we had no restrictions beforehand about the goal of contact in the present study,

[1] The Van der Hoeven kliniek, FPC Dr. S. van Mesdag, Pompestichting and Woenselse Poort.

[2] The Dutch organization Perspective on Mediation (in Dutch: Perspectief Herstelbemiddeling).

i.e., we do not explicitly state that contact should be aimed at achieving moral, psychological, or social repair, we explicitly do not use the term *mediation* but the more neutral term *contact*.

2.3. Procedure

Data was collected between May, 2017 and August 2018. Data was received from 35 social workers about 57 cases.[3] Each social worker was asked to report one case that resulted in contact between victim and offender, and one case that did not result in contact, in order to obtain a nuanced image of both impeding and promoting factors. No other selection criteria were used to include or exclude cases. Social workers were free to choose which case they reported. The boards of the participating hospitals gave permission for data collection and use of the data for this paper.

2.4. Interview

Social workers were interviewed in person or by telephone by the first and second author. The interview was originally developed to evaluate a guideline for social workers about contact between victims and offenders in Dutch forensic hospitals (van Denderen et al., 2019). The first and second author developed the interview, with feedback provided by the third and last author and an advisory committee.[4] For the current study, only the part of the interview pertaining to the research questions as reported in the introduction was used.

2.5. Analysis

To analyse the data, the first and second author performed a content analysis of the 57 cases. This type of design is appropriate for the description of a phenomenon when existing theory is limited (Hsieh & Shannon, 2005). The researchers independently assigned themes to the different questions and then discussed all cases with each other. A theme was defined as an impeding or promoting factor for contact. This led to the formulation of several main- and subthemes. We repeated this process several times, reorganizing the subcategories in multiple main themes. In cases where the two authors found different themes, the concerning category was discussed until agreement was reached.

3. Results

3.1. Description of the cases

Of the 57 cases included in the study, 55 offenders were men. The mean age of the offenders was 42 years (SD = 12.9) the mean age of the victims was 42 years (SD = 17.9).[5] Background information of the offenders is presented in Table 1.

3.2. Initiator, reason for contact and type of contact

Table 2 shows that contact is more often initiated by offenders than by victims, primarily to express their regret or restore contact with victims who are relatives.

As can be seen in Table 3, according to social workers, most contact entails face-to-face contact.

Table 1
Background information about the relation between victim and patient, type of crime and type of psychopathology.

Type	Category	Subcategory	*N*
Relation between the victim and the patient	Relative		17
	(Ex) partner		15
	Friends or acquaintances		12
	Somebody unknown		13
Type of victim	Direct victim		51
	Bereaved individual(s)		6
Type of crime	(Attempted) homicide or manslaughter		20
	Sexual offense		20
	Violent crime		15
	Arson		1
	Threat		5
	Stalking		1
	Violation of the weapon act		1
Psychopathology[a]	Personality disorder[b]	Antisocial	18
		Narcissistic	15
		Borderline	11
		Histrionic	3
		Obsessive compulsive	1
		Avoidant	1
		Not otherwise specified	5
	Schizophrenia and other psychotic disorders		26
	Anxiety and mood disorders		5
	Trauma- and stressor related disorders	PTSD	4
	Developmental disorders	Autism spectrum disorder	12
		Mental retardation	8
		ADHD	4
	Paraphilic disorder		7
	Other	Brain injury through accident	1

Note.
[a] Some patients have multiple mental disorders. Therefore, numbers do not always count up to the total number of cases. Substance abuse was not included in this table.
[b] The numbers reported in this table also include patients who meet several, but not all, criteria for personality disorders.

3.3. General indication by social workers about the benefits of contact for victims and offenders

According to social workers, offenders benefited from contact with the victims because family relationships were restored, offenders received the opportunity to express their regret and obtained answers to questions they had for the victims. Social workers also indicated that some offenders reported feeling less anxious about possible retaliation by the victims. Furthermore, social workers noted that offenders' insight into the circumstances that led to the crime increased and they were better able to cope with the consequences of their crime.

Social workers indicated that victims also benefited from contact with offenders by restoring contact (e.g., when victim and offender were relatives of each other). Furthermore, social workers reported that some victims obtained answers to the questions they had for the offenders, gained insight into the mental illness of the offender, and saw a more complete picture of the offender instead of seeing the offender only as the person who committed the crime. Social workers further noted that victims were able to express the emotional consequences of the crime to the offender, and that in some victims, fear for the offender was reduced.

Social workers also gave examples of situations where victims initiated contact but the offender refused, or vice versa, that still had

[3] The cases were collected at the Van der Hoeven kliniek (n = 15), the FPC Dr. S. van Mesdag (n = 19), the Pompestichting (n = 12) and Woenselse Poort (n = 11).
[4] The advisory committee consisted of four social workers (one from each hospital), hospital psychologists, policymakers and employees of Victim support services and researchers.
[5] Due to missing values, the mean age is based on n = 25 victims.

Table 2
Initiator and reason for contact.

Initiator	Reason for contact	*N*
Patient (*N* = 34)	To express regret	20
	To restore contact with relatives	8
	To restore contact with (ex) partners	4
	To (re) start a relationship with someone	1
	To reduce fear of the victim	6
	To reduce fear of the patient for the victim	1
	To gain insight how the victim is doing	2
	To discuss the crime with relatives in on-going contact	2
	To tell about the circumstances that led to the crime	1
	Discuss practical matters	1
Victim or bereaved individual (*N* = 13)	To restore contact with relatives	6
	To restore contact with (ex) partners	2
	To ask questions or express feelings	6
	To see the person behind the offense	1
Social worker or treatment team (*N* = 8)	To discuss the crime and risks in contact between relatives	3
	To reduce fear by the victim for the patient	1
Other (*N* = 2)	Ongoing contact, initiator is unclear	2

Table 3
Type of contact.

Contact	Type of contact	*N*
Contact (*N* = 29)	Face-to-face	16
	Letter	7
	Phone	3
	By means of a third person who communicates message back and forth.	2
No contact (*N* = 19)	The victim refused	7
	The victim did not respond	4
	The patient refused	3
	Treatment team objected	4
	Other	1
Other (*N* = 9)	Case is still ongoing	9

some positive effect. For example, a mother who was severely abused by her son with a schizophrenic disorder, was not yet ready to meet him. However, she received psycho-education about the mental disorder of her son by the social worker and gained insight into the way she could best approach him at a later stage. An offender with autism spectrum disorder wrote a letter to the victim he had abused. He was disappointed and frustrated that the victim did not respond to his letter. This was incorporated into the offender's treatment, using the situation to approach the subject of how to cope with frustration. These cases that did not lead to contact between both parties were subject to the same conditions of voluntariness and safety for the all individuals involved. Initially, there were sufficient grounds to start the process, although during the process, one or both of the parties declined further participation. As these examples show, the process might be beneficial for offenders or victims, even though the process does not result in actual contact with each other.

3.4. Offender characteristics to consider when making decisions about contact with victims[6]

Based on their prior knowledge and experience with these types of cases, social workers reported several offender characteristics deemed important to consider in making decisions about contact with victims.

3.4.1. (Limited) problem awareness and reflective abilities

A number of offenders showed that they were aware of the suffering they had caused to their victim. As the social workers indicated, these offenders were willing to take ownership of the crime, were considered sincere in their wish to apologize and were able to reflect on the consequences of their criminal behaviour. They were able to give their victim insight into the background of their criminal behaviour and showed remorse about the harm they had caused, according to the social workers. In one case, an offender with intellectual disabilities who forced a girl to perform sexual acts, wrote her a letter to offer his apologies. According to the treatment team, his initiative fitted well into his treatment plan. In the past, he had held others responsible for everything that went wrong in his life. During his forensic treatment, he gained insight into the aspects that he was responsible for himself, among which his offense. The offender acted on this insight by sending a written apology to the victim.

On the contrary, lack of problem awareness may be problematic for victim-offender contact. For example, offenders with a diagnosis of (traits of) an antisocial and/or narcissistic personality disorder or a high level of psychopathy as assessed using the Psychopathy Checklist-Revised (Hare, 2003), were considered to have limited ability to empathize with their victims or to understand the harm they had caused them. The social workers reported that this manifested itself in regrets that did not seem sincere, regrets that seemed purely functional (e.g., in order to present themselves favourably in court), or responses to the victim that were egocentric in nature instead of compassionate towards the victim. In other instances, offenders felt primarily sorry for themselves for being convicted and trivialized the consequences of the crime for the victim. In these cases, it was judged by the social workers that contact might lead to further victimization of the victim instead of recovery. An example was an offender who attacked an unknown woman. He could not understand why she was still afraid of him. The offender considered that the chance they would meet again would be small as they lived in separate parts of the country. Since he trivialized the harm he caused her, the social worker and treatment team judged that at this moment, contact with the victim might further harm her. Also, limited empathy and limited problem awareness sometimes led to unrealistic expectations of offenders about what could be achieved by meeting the victim. For instance, some offenders with autistic spectrum disorder strongly believed that meeting the victim could lead to a renewed relationship with the victim. Their convictions were persistent, even though they had not seen the victim for years, harmed them severely or barely knew the victim at all.

3.4.2. (Un)stable psychiatric or physical condition

Social workers noted that another offender characteristic that facilitated contact, is a stable psychiatric condition of the offender. In one case, an offender with a psychotic disorder had raped a woman. The victim initiated contact because she wanted to see the person ‘behind the crime’. During the time that his psychiatric condition was unstable, the offender was unable to comprehend the hurt he had caused her, and contact with the victim at this stage was not yet considered desirable for both the victim and offender. During his treatment, the offender stabilized, and his anger and psychoses became less prominent. When contact with the victim took place, the offender could answer her questions and explain that he suffered from a severe mental disorder. By meeting the offender, the victim was able to reconstruct the image she had of him, to see him as a person instead of a ‘monster’ and she became less afraid of him.

In this example, the offender's psychiatric condition was taken into account by the treatment team in planning contact at a later time when the offender was stabilized. In other cases, the offenders' psychiatric condition was reason to refrain from contact. In some cases, the

[6] Although this section is called ‘offender characteristics’, the reported characteristics may also be present in victims. Since we have less information about these characteristics in victims, we limit ourselves to offender characteristics in this paper.

treatment team judged that victim-offender-contact might lead to psychiatric decompensation in the offender, particularly in offenders with schizophrenia or other psychotic disorders. In another case, the medical condition of the offender was reason for the treatment team to hesitate in regard to contact with the victim, since they thought that excessive stress would be a risk factor to the offender's physical health.

3.4.3. (In)ability to keep agreements

According to social workers, a prerequisite for facilitating victim-offender-contact is that both the victims and the offenders are seen as reliable and are able to keep to agreements made during the preparatory phase. This is to ensure that the chances that the victim or offender will be confronted with unexpected behaviour of either or both during contact are kept to a minimum.

3.5. How were any impeding factors accounted for in practice?

Impeding factors were, to some extent, present in most cases in the present study. However, this did not automatically mean that victim-offender contact was impossible. Usually, a multidisciplinary team, including the social worker, treatment supervisor and a neutral mediator, weighed the promoting and impeding factors and discussed how possible impeding factors could be taken into account. The main priority in this decision-making process is the physical and mental safety of everyone involved in the process. According to the social workers interviewed in the present study, impeding factors might be accounted for in the following ways.

3.5.1. Careful preparation and balancing expectations

A detailed preparation is important in every case. It includes conversations with the victim and the offender separately about their goals, limitations and expectations, in such a way that the chance of unforeseen circumstances during the actual meeting is kept as low as possible. A careful preparation contributes to the practical and mental preparation of both the victim and offender. Balancing expectations of both parties is even more crucial when victims or offenders have unrealistic ideas about what could be achieved by meeting the other. Both victims and offenders have to become aware of the possibility that the other might reject the initiative for contact or expresses anger or other emotions during the meeting. For example, it had not occurred to an offender who had sexually abused his daughter that she could be angry with him or could refuse contact. In the preparatory phase, the psychotherapist discussed several scenarios with the offender about how his daughter might act when they would meet each other. It took several sessions before the offender could acknowledge that she might have experienced the offense differently than he had. Subsequently, he was more open to the possibility that she might be angry with him. During the meeting, the daughter did express her anger and resentment towards him. Despite the fact that the offender was disappointed by her reaction, he was able to listen to her side of the story, because he had already expected, and thereby partly processed, her reaction.

3.5.2. Choosing an appropriate type of contact

Another way to account for possible impeding factors is to carefully consider the type of contact. The most reported reason to prefer contact by letter instead of face-to-face was that the treatment team is able to carefully monitor the content. This is important in situations where offenders have difficulty sensing what is appropriate social behaviour. For instance, understanding the circumstances that led to the crime might help victims. However, it is misplaced when offenders use these circumstances as an excuse for their behaviour. The content, extent and degree to which offenders elaborate about such circumstances are easier to monitor by the treatment team via contact by letter or via a neutral third person.

3.5.3. Prohibiting contact

In some cases, the treatment team concluded in the preparatory phase that it was better for the wellbeing of either the victim or offender to prohibit contact. Forbidding contact may be necessary in cases where offenders or victims have a restraining order, or the treatment team judges that contact will do further harm to one or both parties. In one case, the treatment team considered an offender not sincere in his wish to apologize to the victim. They believed that the offender was more preoccupied with his own needs than with the hurt he caused the victim. Considering this perceived lack of insight from the offender, the treatment team decided not to reach out to the victim regarding the request from the offender, because the offender may do further harm to the victim during contact.

4. Discussion

This exploratory study is aimed at providing insight into contact between victims and mentally disordered offenders who reside in four Dutch forensic psychiatric hospitals. To our knowledge, this is the first study examining contact between victims and offenders with a severe mental disorder. To this end, we analysed the experience of 35 social workers by interviewing them on 57 cases with regard to the offenders' psychopathology, the offense, the relation between victim and offender, the person who initiated the contact, the course of contact, and possible impeding and promoting factors for contact. Our main finding was that offenders who committed serious offenses and who suffer from severe mental disorder are generally capable of having contact with their victim, depending on the aim and the type of contact. Social workers did not indicate types of disorders or types of offenses for which contact with their victim was ruled out *by definition*. More research in larger populations and more insight into the reasons why victims decline contact (for example whether those reasons are related to the mental disorder of an offender) is needed to confirm this preliminary finding.

As reported by the social workers, victim-offender contact may have several benefits. Some victims obtained answers to their questions and were able to express the emotional consequences of the crime to the offender. Offenders were able to express their regret to the victim and to restore contact with relatives (who were also victims). Furthermore, social workers reported that an encounter between a victim and offender does not always have to focus on emotional recovery or understanding of the offenses. Making concrete agreements, for instance, that victim and offender do not see each other during the offender's leave, could also give peace of mind for those involved. Our findings are largely in line with findings from studies about victim-offender contact in other phases of the judicial process, for instance, pre-sentence as addition to criminal prosecution, or in prison populations. Similar benefits of victim-offender contact are, for example, the possibility of obtaining answers and decrease of fear for the offender among victims (Strang et al., 2006; Umbreit, Vos, Coates, & Armour, 2006). It remains unclear to what extent mental health problems of prisoners are a factor in the establishment of contact with victims during incarceration and more research is definitely needed.

Another important finding was that the preparatory process might be beneficial for victims and offenders, even when this does not result in actual contact. An example was an offender who felt frustrated when the victim refused contact, but learned how to effectively cope with such feelings. This is in line with research of Cook et al. (2015), who found that individual preparatory work was deemed to have value, even when not culminating in a meeting between victim and offender.

Offender characteristics that facilitated victim-offender-contact as reported by the social workers interviewed in the present study were problem awareness, reflective abilities and a stable psychiatric condition. Limited problem awareness, poor understanding of the harm inflicted on victims and unrealistic ideas about what could be achieved by meeting the victim were considered to be potentially complicating factors concerning victim-offender-contact. An important finding was

that in most cases, it was possible for the social workers to take the offenders' impeding characteristics into account in such a way that contact could proceed. Offenders without regret for their offense might, for example, still be able to answer questions from victims. Managing expectations between all parties is crucial here. In this regard, it has been estimated that 90% of the work happens before the actual contact between victim and offender (see Drennan, 2018).Sometimes the decision was made not to disallow contact in its entirety, but to postpone it until an offender is better adjusted to anti-psychotic medication, or to have contact by letter instead of face-to-face contact. The findings of this study suggest that the offenders' psychopathology is not necessarily decisive for contact with the victim. Much depends on the skills of the social worker and the treatment team and how the psychopathology is managed, and on finding a form in which contact can proceed safely. This is in line with the opinion of other scholars, who state that victim-offender contact or RJ practices with mentally disordered offenders might be (more) challenging, and therefore require trained facilitators who are familiar with and trained to work with these types of offenders (Garner & Hafemeister, 2003; Wild, 2016). In the Restorative Justice Council Practitioner's Handbook (2016), cases in which the offender has a mental illness are by definition regarded as complex and sensitive, and, thus, require a high level of expertise from the professionals that guide these processes.

As stated in the introduction, some of the cases described in this paper might be restorative in character. Bearing that in mind, it appears that the potential positive effects of victim-offender contact on the offenders' treatment are in line with research of Hafemeister et al. (2012) about restorative practices. They report that restorative practices might contribute to offenders gaining insight into the effect of their actions on victims, in the nature of their disorder and to more commitment to their rehabilitation process. One of the most frequent reasons for (and also consequences of) victim-offender-contact was restoring ties between relatives. This is in line with other findings, in which restorative practices have been shown to help offenders strengthen their social support networks. This may, in turn, result in greater opportunities for rehabilitation when the offender is discharged from the forensic psychiatric hospital (Hafemeister et al., 2012). A stable home environment and strong pro-social support are found to be protective factors for repeated violent behaviour (de Vogel, Robbé, de, de Ruiter, & Bouman, 2011). As such, contact with pro-social family members who were former victims might have a potential positive influence on offenders with regard to achieving treatment goals and better rehabilitation possibilities. As reported earlier, these topics are not only relevant in actual victim-offender-contact but also when preparatory work does not lead to actual contact (see also Drennan et al., 2015).

An important issue to consider is the timing of contact. According to social workers, one of the decisive factors in this regard is the condition of the offender's mental disorder. We found that a stable situation of the offender's mental disorder (for example in case of offenders with a psychotic disorder) and realistic expectations of contact with victims are encouraging factors for victim-offender-contact. This is consistent with the vision of Garner and Hafemeister (2003), who wrote a theoretical paper about restorative approaches in the United States. They state that RJ approaches should encompass mentally disordered offenders when they are psychologically stable enough, and possess sufficient skills to engage in a meaningful conversation with their victims. Following from this, delusions, psychoses or unrealistic expectations might not necessarily be exclusion criteria, but a temporary barrier to contact with victims (Sampers et al., 2008).

4.1. Clinical implications

Important facilitating factors in victim-offender contact are offenders' awareness of the consequences of one's own behaviour, insight into the harm caused to victims and taking responsibility for the offense. These factors are important themes in forensic treatment. Contact with the victim in forensic hospitals might, therefore, have a potential positive influence on the offenders' treatment. Arguably, insight into the consequences of their crimes by offenders and forgiveness by the victims might not have a direct effect on recidivism or treatment goals, but might have an indirect effect, by contributing positively to stronger motivation for treatment. Stronger motivation for treatment is in turn associated with higher engagement in treatment and therapeutic change (O'Brien & Daffern, 2017; Olver, Stockdale, & Wormith, 2011).

In the present study, social workers did not indicate that there are types of mental disorders or offenses for which contact with their victim was ruled out by definition. In terms of clinical implications, this could mean that contact with victims should not be discouraged beforehand for specific subtypes of offenders. Facilitating contact between victims and offenders is a complex process that should be guided by highly trained professionals, preferably in multidisciplinary teams. It is important that management of forensic mental health hospitals assist their professionals in doing their work as well as possible, for example by providing sufficient time, training and means for organizing victim-offender contact.

4.2. Limitations and suggestions for further research

When interpreting the results, several limitations have to be taken into account. The results were obtained by interviewing social workers who were closely involved in the process about their experiences with victim-offender contact. The results are therefore exploratory and should be interpreted with caution. The generalization of this study is limited: the study was conducted in only four of the eleven large forensic centres in the Netherlands and performed in a relatively small sample. More generally, there are important differences between countries with regard to their legal system, how they deal with victims and which victim organizations are present. Another limitation is that the positive experiences of victims and offenders as described in this study might be due to selection biases. Our recruitment strategy might also have caused a selection bias. Cases were not randomly selected by social workers; rather, they were curated. They might have been more inclined to report about cases with more positive benefits for victims and offenders. Furthermore, insight into the benefits of victim-offender contact was gained indirectly, via the offender's social worker. To gain a better and more detailed understanding of the influence of contact on the lives of victims and offenders, victims and offenders should be asked themselves in future research about what they gained from contact with each other. For future research, it is also advised to explore whether an offender's changed motivation or insight holds for the longer term and what it means in terms of behaviour in daily practice. Another suggestion for future research is to study in more detail how contact with offenders may benefit victims. In the present study, social workers indicated that contact with the offender helped victims cope with the offense. They reported different ways on how the needs of victims were met, such as questions being answered by the offender, the expression of the emotional consequences of the crime and feeling less fearful of the offender. However, we do not know how these different factors interact with each other. How do victims define coping with the offense, and how do these different factors contribute to a more helpful way of coping with the offense? More research, both quantitative and qualitative, is needed to provide insight into the ways in which contact with mentally disordered offenders may help victims in processing their experiences. Notwithstanding these limitations, this is the first study that describes cases of offenders with a severe mental disorder who were able to participate in contact with their victim.

Declaration of competing interest

None.

Acknowledgement

The authors wish to thank the social workers who participated in this study, and H. Visser, for providing assistance in language editing.

Funding

This work was supported by the Dutch program Kwaliteit Forensische Zorg (Quality Forensic Care), [grant number 2016-60].

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Angel, C. M., Sherman, L. W., Strang, H., Ariel, B., Bennett, S., Inkpen, N., ... Richmond, T. (2014). Short-term effects of restorative justice conferences on post-traumatic stress symptoms among twelve experiments in restorative justice: The Jerry Lee program 535 robbery and burglary victims: A randomised, controlled trial. *Journal of Experimental Criminology, 10*, 291–307. https://doi.org/10.1037/t12199-000.

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

Daly, K. (2003). Mind the gap: Restorative justice in theory and practice. *Restorative justice and criminal justice: Competing or reconcilable paradigms* (pp. 219–236). .

van Denderen, M., Verstegen, N., de Vogel, V., & Feringa, L. (2019). Handreiking Slachtofferbewust Werken voor Forensisch Maatschappelijk Werkers [Guideline Victim Awareness for Forensic Social Workers]. Available http://www.kfz.nl/projecten/call-2016-60.

Drennan, G. (2018). Restorative justice applications in mental health settings – Pathways to recovery and restitution. In J. Adlam, T. Kluttig, & B. X. Lee (Eds.). *Violent states and creative states: From the global to the individual. Book II: Human violence and creative humanity* (pp. 181–194). London: Jessica Kingsley Publishers.

Drennan, G., Cook, A., & Kiernan, H. (2015). The psychology of restorative practice in forensic mental health recovery. In T. Gavrielides (Ed.). *The psychology of restorative justice. Managing the power within* (pp. 105–120). . https://doi.org/10.4324/9781315553788.

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

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

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

Hare, R. D. (2003). *Manual for the hare psychopathy checklist-revised.* Toronto, ON: Multi-Health Systems.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687.

Jonas-van Dijk, J., Zebel, S., Claessen, J., & Nelen, H. (2019). Victim–offender mediation and reduced reoffending: Gauging the self-selection bias. *Crime and Delinquency*. https://doi.org/10.1177/0011128719854348.

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

Livingstone, N., Macdonald, G., & Carr, N. (2013). Restorative justice conferencing for reducing recidivism in young offenders (aged 7 to 21). *Cochrane Database of Systematic Reviews, 2*. https://doi.org/10.1002/14651858.CD008898.pub2 Art. No.: CD008898.

van Marle, H. J. C. (2002). The Dutch entrustment act (TBS): Its principles and innovations. *International Journal of Forensic Mental Health, 1*, 83–92. https://doi.org/10.1080/14999013.2002.10471163e.

O'Brien, K., & Daffern, M. (2017). Treatment gain in violent offenders: The relationship between proximal outcomes, risk reduction and violent recidivism. *Psychiatry, Psychology and Law, 24*(2), 244–258. https://doi-org.proxy-ub.rug.nl/10.1080/13218719.2016.1209804.

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*(1), 6–21. https://doi-org.proxy-ub.rug.nl/10.1037/a0022200.

Power, M. (2017). International innovations in restorative justice in mental health – Next steps for Australia. Retrieved from https://www.griffith.edu.au/_data/assets/pdf_file/0019/107443/Michael-Power-Churchill-Fellowship-Restorative-Approaches-in-Mental-Health-V2.pdf.

Restorative Justice Council (2016). RJC practitioner's handbook. Retrieved from https://restorativejustice.org.uk/resources/rjc-practitioners-handbook.

Robinson, G., & Shapland, J. (2008). Reducing recidivism: A task for restorative justice? *British Journal of Criminology, 48*(3), 337–358. https://doi.org/10.1093/bjc/azn002.

Sampers, P., Bataillie, D., Dufrainig, D., & Marchal, A. (2008). Bemiddelen tussen Daders met Ernstige Persoonlijkheidsstoornissen en hun Slachtoffers [Mediation between offenders with severe personality disorders and their victims]. *Nieuwsbrief Suggnomè, forum voor herstelrecht en bemiddeling, 3*, 4–9.

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

Stewart, L., Thompson, J., Beaudette, J. N., Buck, M., Laframboise, R., & Petrellis, T. (2018). The impact of participation in victim-offender mediation sessions on recidivism of serious offenders. *International Journal of Offender Therapy and Comparative Criminology, 62*(12), 3910–3927. https://doi.org/10.1177/0306624X17752274.

Strang, H., Sherman, L., Angel, C. M., Woods, D. J., Bennett, S., Newbury-Birch, D., & Inkpen, N. (2006). Victim evaluations of face-to-face restorative justice conferences: A quasi-experimental analysis. *Journal of Social Issues, 62*(2), 281–306. https://doi-org.proxy-ub.rug.nl/10.1111/j.1540-4560.2006.00451.x.

Thomas, E. C., Bilger, A., Wilson, A. B., & Draine, J. (2018). Conceptualizing restorative justice for people with mental illnesses leaving prison or jail. *The American Journal of Orthopsychiatry*. https://doi.org/10.1037/ort0000316.

Umbreit, M. S., Vos, B., Coates, R. B., & Armour, M. P. (2006). Victims of severe violence in mediated dialogue with offender: The impact of the first multi-site study in the US. *International Review of Victimology, 13*(1), 27–48. https://doi.org/10.1177/026975800601300102.

de Vogel, V., Robbé, V., de, M., de Ruiter, C., & Bouman, Y. H. A. (2011). Assessing protective factors in forensic psychiatric practice. Introducing the SAPROF. *International Journal of Forensic Mental Health, 10*, 171–177. https://doi.org/10.1080/14999013.2011.600230.

Wemmers, J., & Cyr, K. (2005). Can mediation be therapeutic for crime victims? An evaluation of victims' experiences in mediation with young offenders. *Canadian Journal of Criminology and Criminal Justice, 47*, 527–544. https://doi.org/10.3138/cjccj.47.3.527.

Wild, C. (2016). Can restorative justice be effective with victims and offenders with a mental disorder? A note on challenges, development and outcomes. *Forensic Update 2015 Annual Compendium*. British Psychological Society.

Zebel, S., Schreurs, W., & Ufkes, E. G. (2017). Crime seriousness and participation in restorative justice: The role of time elapsed since the offense. *Law and Human Behavior, 41*(4), 385–397. https://doi.org/10.1037/lhb0000242.

Zinsstag, E., & Keenan, M. (Eds.). (2017). *Restorative responses to sexual violence: Legal, social and therapeutic dimensions*London, England: Routledge. https://doi.org/10.4324/9781315630595.