Dilemmas in applying strengths-based approaches in working with offenders with mental illness: A critical multidisciplinary review

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Abstract

The recent focus on extending risk assessment and treatment in forensic mental health with protective factors relates to the increasing interest in strengths-based approaches in various professional disciplines: law (e.g. human rights), criminology (e.g. desistance), mental health care (e.g. recovery), forensic psychology (e.g. the Good Lives Model), special needs education (e.g. Quality of Life) and family studies (e.g. family recovery). In this article, we will discuss the available knowledge with regard to strengths-based approaches for offenders with mental illness, in relation to these different disciplines. Several dilemmas are observed across these disciplines: *(1)* "Living apart together": the integration of different disciplines; *(2)* "Beyond Babylonian confusion and towards more theoretical research": conceptualization of strengths-based practices in different fields; *(3)* "No agency without autonomy": the individual in context; and *(4)* "Risks, strengths and capabilities": the search for an integrated paradigm. In our view, these different disciplines share a shift in how humankind is viewed, respecting agency in the interaction with people who have offended. Yet, differences apply to the objectives that the disciplines strive for, which warrants not to eclectically consider strengths-based working in each of the disciplines as '*being small variations of the same theme*'.

Keywords: Strengths-based approach; Protective Factors; Desistance; Recovery; Procedural Justice; Good Lives Model

Highlights:

- A strengths-approach starts from an abilities- instead of a deficit-based viewpoint
- Different disciplines in forensic mental health share a strengths-based shift
- Differences apply to the objectives of disciplines in forensic mental health
- An *eclectic* multidisciplinary approach in forensic mental health should be avoided
- The article adopts a holistic - integrative view on risks, strengths, capabilities

1. Introduction

Treating offenders with mental illness and protecting society are to be considered as essential parts of an integrated approach to this population (Ward et al., 2011). In recent years, (risk) assessment and treatment for offenders with mental illness have been influenced by strengths-based approaches, targeting not only risks, deficits and problems, but also tapping into capabilities, dreams and aspirations. There seems to be consensus on the fact that risk assessment and treatment in forensic mental health services should incorporate (1) historical/static, (2) dynamic as well as (3) protective factors (de Ruiter & Nicholls, 2011). This relates to current strengths-based approaches in different disciplines: l*aw* (e.g. human rights), *criminology* (e.g. the desistance paradigm), *mental health care* (e.g. the recovery-paradigm), *forensic psychology* (e.g. the Good Lives Model), *special needs education* (e.g. Quality of Life-approach) and *family studies* (e.g. family recovery).

In one of the other papers in this special issue, Ward (*this issue*) raises several problems with regard to the theoretical underpinning and conceptualization of protective factors and other terms that are often used as synonyms or at least as related concepts, including resilience and strengths. One of the difficulties mentioned relates to the lack of clear definitions, as people may wrongfully assume that these concepts, exactly because of the positive associations they evoke, are intrinsically valuable and therefore should not be critically examined (Ward, this issue). In this article, we will discuss and reflect on how strengths-based approaches for offenders with mental illness are conceptualized, in relation to these different disciplines mentioned above. We will start by describing the strengths-based paradigm after which we will focus on the current state of the art and pending questions in each discipline. In the discussion section, a number of dilemmas will be elaborated.

This theoretical article draws on an ongoing multidisciplinary research project on the development of multidisciplinary strengths-based strategies, which offers a unique opportunity to study different aspects of strengths-based approaches for offenders with mental illness (Vander Beken et al., 2016). Because of the broad diversity of disciplines involved in supporting and treating offenders with

mental illness, we specifically focused on the fields of psychiatry, criminology, law, and special needs education as these are also represented in the research project. These disciplines obviously use different terminologies and theoretical models with regard to strengths-based approaches, but are - at the same time - contributing to a more global and holistic perspective.

Throughout the text, the term *offender with mental illness* will be used instead of other concepts (e.g., mentally ill/disordered offenders, forensic psychiatric patients, ….). By so doing, we aim to focus on the fact that – first and above all – offenders are human beings (Ward, 2012a).

2. The strengths-based paradigm

Over the last decades, the strenghts-based approach in social work has been conceptualized and operationalized by several authors (e.g. Rapp & Sullivan, 2014; Saleebey, 2006). Still, the term is often loosely used to denominate a variety of practices, reflecting a generally poor understanding of what strengths-based work really consists of (Rapp, Saleebey and Sullivan, 2005). Rapp and colleagues have identified the following six key "i*ngredients*" of the strengths-based model (Rapp et al., 2005; 2014, p. 132): (1) persons who experience (e.g., mental health) problems have the capacity to grow; (2) it is essential to move beyond deficits and emphasize strengths, which have to be mapped systematically; (3) the focus is placed on the context and its natural resources; (4) the client is 'in control' of his/her treatment or support process, e.g. in regard to defining the goals that are personally meaningful to him or her; (5) the relationship between professional and client is key and contributes to fostering hope; and (6) strengths-based practice should – if possible – take place in the natural surroundings/the community. These six characteristics clearly show that strengths-based approaches comprise individual and interpersonal competencies (Tse et al., 2016), as well as community resources (Hui et al., 2015).

According to Rapp and colleagues (2014, p. 134), the evidence base for strengths-based approaches is "*far from conclusive yet promising*". In a recent theoretical study on the development and evolution of the strengths model, Rapp and colleagues (2014) refer to the effect of strengths-based

case management for substance misusers on treatment retention, that – in its turn – predicts better outcomes (Siegal, Li & Rapp, 2002). Further, they make reference to studies that showed increased employment rates and less criminal involvement when a strengths-based approach for substance abusers was implemented (Siegal et al., 1996). More recently, Tse et al. (2016) performed a systematic literature review on the effects of strengths-based interventions for persons with serious mental health illness. Findings indicate positive results on various indicators, including treatment retention, treatment satisfaction, education and employment rates, recovery-promoting attitudes and service utilization. Yet, one study also showed less favorable results of strengths-based case management on post-treatment social network and symptom indicators, compared with treatment as usual. The authors conclude that their *"(…) review has revealed emerging evidence that the utilisation of a strength-based approach is effective for yielding desirable outcomes, including 'hard' outcomes such as duration of hospitalisation, adherence to treatment and employment/educational attainment, as well as 'soft' outcomes such as self-esteem, self-efficacy and sense of hope*" (Tse et al., 2016, p. 289).

2.1. Strengths-based approaches across various disciplines dealing with offenders with mental illness

2.1.1. Law: Human rights

Human rights approaches constitute important ethical and therapeutic resources for academics and practitioners working from a strengths-based and Quality of Life (QoL)-oriented perspective. Human rights are considered to facilitate the process of rehabilitation and treatment and direct attention to the conditions required for individuals to live socially acceptable and personally meaningful lives (Connolly & Ward, 2008). Quality of Life emphasizes shared humanity and points out that even individuals who have committed the most unpalatable crimes are striving to lead good lives. From

that perspective, recognition of our commonality of purpose makes the violation of human rights less tenable (Barnao et al., 2016).

In fact, the fundamental values expressed in QoL and legal human rights standards are identical. QoL is conceptualized and operationalized more at the level of individual support with a view to clinical use, while legal human rights instruments and standards better address social-political implications at the societal level (Buntinx, 2013).

However, from the perspective of the legal discipline in general, and the field of human rights and criminal law in particular, the connection to and values shared with QoL stay under the radar. Moreover, therapeutic approaches that are inspired from a human rights-based perspective mainly take a general and fundamental interest in human rights, without following and connecting to new developments in the legal field.

With regard to offenders with mental illness, a new legal development concerns their effective participation in criminal proceedings. Traditionally, criminal justice systems have viewed offenders with mental illness as persons committing acts that make them a danger to society. As a consequence of a predominantly risk-driven criminal justice intervention, the legal position of the offender with mental illness has been of no real concern. Offenders with mental illness were often treated as objects rather than subjects in the proceedings, because of the emphasis on the potential criminal consequences of their mental status (i.e. recidivism). This resulted in a failure to take into account their capacities and remaining opportunities, largely ignoring their voices during the proceedings. This implied that, even under the existing human rights standards, authorities could be satisfied when the defendant with mental illness was represented by a lawyer during criminal proceedings (Salize, Dressing and Kief, 2007; Salize and Dressing, 2005). From the point of view that this population might need additional procedural safeguards in order to understand and follow legal proceedings (Nemitz & Bean, 2001), arguments are made that the mere assistance of a legal representative is insufficient to guarantee the rights of persons with mental illness. Similarly, case

law of the European Court for Human Rights' (ECtHR) now states that defendants with mental illness have a right to participate in criminal proceedings from the earliest stage of police interrogation (Verbeke et al. 2015). This legal evolution with regard to the right to effective participation could be a source of normative and ethical inspiration to those who provide treatment or care to offenders with mental illness. Indeed, it outlines and emphasizes the duty to protect individuals' well-being and freedom by enabling them to play an active role in the whole process and by doing so supporting them to have a major say in what kind of life goals to pursue and how to do so (Day and Ward, 2010: 302).

2.2.2. Law, Criminology & Psychology: Procedural Justice

Another potentially relevant field that might inspire therapeutic and clinical work with offenders with mental illness is that of procedural justice theory and research. Procedural justice offers a framework that stresses the importance of people perceiving social processes and procedures as just and fair (Lind et al., 1990). The background of this theory is that people place greater significance on the process and the procedures of social interaction rather than the outcome of this interaction. Six aspects of procedural justice are defined: 1) experiencing the procedures as objective, fair and/or neutral (fairness); 2) the experience of being able to express one's own view (voice); 3) the experience of holding a view that is taken into account (validation); 4) the experience of being treated with dignity and respect (respect); 5) the experience of being treated with genuine concern (motivation) and 6) the experience of being informed regarding the procedures (information) (Lind, et al., 1990). An implication of procedural justice theory is that it can be a tool to improve the quality of social interactions and the satisfaction of all parties involved by adjusting the shape of procedures without necessarily adjusting the outcomes of these procedures (Lind and Tyler, 1988). Experiencing procedural justice results in higher satisfaction, more positive emotions and more prosocial behavior of the individuals involved (Tyler, 2009). When not used as an instrument to attain socially desired outcomes but as a fundamental right of people (Wittouck et al, 2016), experiencing procedural

justice can be regarded as a mechanism of change and can serve as an instrument for therapeutic jurisprudence (Canada and Watson, 2013).

So far, most studies that have looked at the outcomes of procedural justice in offenders with mental illness have been conducted in a law enforcement setting (police, courts, mental health courts), but not in prisons. They found that experiencing procedural justice was associated with a better quality of the relationship between the law enforcement official (or judge) and the offender with mental illness, less perceived coercion and less perceived negative pressure and more positive feelings towards one's recovery and desistance (Wittouck et al., in press). A (single) study on outcomes of procedural justice in forensic psychiatric patients showed that those who have experienced higher levels of procedural justice, and especially 'voice' and 'validation', perceived less coercion during the admission procedure (McKenna et al., 2003). While research on procedural justice in offenders with mental illness is fragmented and even scarce in non-law enforcement settings, this framework has great potential for those who provide treatment or care to offenders with mental illness. As is the case for human rights approaches, procedural justice standards might offer them a normative framework to help offenders with mental illness to pursue a good life through interactions that pay attention to fairness, respect and human dignity.

2.2.3. Forensic psychology – The Good Lives Model of offender rehabilitation (GLM)

In forensic psychology, three different paradigms can be distinguished regarding the rehabilitation of mentally ill individuals who have committed offences (Robertson et al., 2011). The *risk paradigm* is situated within a criminal justice approach, focusing on assessment and management of the risk of reoffending. The *psychopathology paradigm* is situated within a mental health approach, focusing on treatment of mental illness (Barnao et al., 2010). Offenders with mental illness are often described as being in double jeopardy (Grisso, 2004), which refers to the co-occurrence of offending behavior and mental health problems, implying dual impairments, risks, needs and challenges. Consequently, the risk and psychopathology paradigm are often combined in order to address the individual's complex

rehabilitation needs. However, such a blended approach is deemed problematic, as both paradigms adopt different and even conflicting values, assumptions and aims (Barnao & Ward, 2015). Consequently, a comprehensive and tailored rehabilitation framework is needed for the particularly vulnerable population of offenders with mental illness.

The Good Lives Model of offender rehabilitation (GLM) was designed as a rehabilitation framework for adult offenders (Ward & Brown, 2004). The GLM is a strength-based empowering rehabilitation framework given its focus on two goals that are inextricably linked, being the fulfillment of offenders' primary goods and the reduction of their risk to reoffend (Ward et al., 2007). According to the GLM, all humans strive for the realization of a range of primary goods. This idea emphasizes commonality, thereby challenging violation of human rights which is often underpinned by processes of "othering" (Barnao et al., 2010). Secondary goods provide the means to fulfill one's basic human goods. Adopting appropriate secondary goods (e.g., working to obtain material well-being) support true fulfillment of one's primary goods, while adopting inappropriate secondary goods (e.g., stealing) only yield temporary or minimal fulfillment of one's primary goods. Internal and external capacities/obstacles, respectively, enhance/impede the fulfillment of one's primary goods (Purvis et al., 2011). By addressing both individual/personal and environmental/structural capacities and obstacles, the GLM stresses the importance of considering individuals as social beings, who are mutually interdependent and who pursue the construction of their own good lives within a social context (Robertson et al., 2011).

The GLM has been applied to a broad range of offender populations, yet only scantly to offenders with mental illness. The limited number of papers that applied the GLM to forensic mental health populations suggest that the GLM-forensic modification (GLM-FM) provides a comprehensive strength-based framework for guiding treatment planning (Robertson et al., 2011; Barnao & Ward, 2015). The GLM-FM adds 'mental illness' to the model, which may serve as an obstacle for the

fulfillment of one's primary goods, while some symptoms of mental illness may also serve as inappropriate secondary goods to fulfill one's primary goods (Barnao et al., 2010).

The past decade, conceptual and theoretical issues (Ward & Brown, 2004), implications for clinical practice and policy (Purvis et al., 2011), and the effectiveness of GLM-informed interventions (Barnett et al., 2014) have been studied quite extensively. However, statistical evidence in support of or against the basic, theoretical assumptions of the GLM is still very thin, particularly regarding the GLM-FM (Barnao & Ward, 2015). We are aware of only two empirical studies that tested the GLM in adults or youth in forensic mental health services. The first study confirmed the assumption that the fulfillment of one's primary goods reduces the risk of both short-term and long-term offending behavior in forensic psychiatric outpatients (Bouman et al., 2009). The second study, conducted among adolescents in youth forensic psychiatry, confirmed the following assumptions: (i) unfulfilled primary goods are associated with unfavorable outcomes, such as mental illness or offending behavior; (ii) internal obstacles (e.g., passive coping strategies) hinder the fulfillment of one's primary goods; and (iii) internal capacities (e.g., adequate coping skills) are related to less offending behavior and psychosocial problems at follow-up (Barendregt, 2015). However, in these young people, unfulfilled primary goods are not associated with offending behavior at follow-up (Barendregt, 2015).

Some challenges with regard to the implementation of the GLM to forensic populations could be discerned. The first challenge relates to patients' double jeopardy, which is closely related to practitioners' double role in forensic mental health services, simultaneously combining support and restriction (Blackburn, 2004). The second challenge relates to the potential benefits and pitfalls of treatment in forensic mental health services (Barnao et al., 2010; Robertson et al., 2011). On the one hand, treatment in these services may serve as a facilitator of fulfilling one's primary goods, for example, by identifying and addressing both individual/personal and environmental/structural capacities/obstacles that, respectively, supported/hampered true fulfillment of one's primary goods

(Barnao et al., 2011). On the other hand, treatment in these services is likely to serve as an obstacle for fulfilling certain primary goods, for example, by restricting one's autonomy, hampering the possibility to practice new skills, fostering social disadvantage through stigma and discrimination (Barendregt et al., 2012). In this respect, the structured, artificial, and segregated nature of forensic mental health facilities forms a major challenge and urges critical reflection.

2.2.4. Mental health care: The emerging recovery movement

Following the deinstitutionalization in mental health care, community-based services and individual case management have largely replaced the 'total institutions' of the 1960s and 70s. Although economic motives promoted this shift, it was aimed at stimulating the participation and social integration of persons with mental health problems, at improving their quality of life and at empowering them to become self-supportive (Tyrer, 2011). This evolution has challenged the traditional medical model, which is based on classification, pharmacological treatment and psychotherapy and aimed at cure and alleviation of symptoms. In reaction against what is perceived to be an overly narrow biomedical approach, the emerging recovery movement emphasizes the importance of client-centered and strengths-based strategies, starting from individuals' perceived needs and applying goal-directed practices that reflect their aspirations (Thornton & Lucas, 2011; Vanderplasschen et al., 2013). Clients' roles and strengths in regaining active control over one's life are highly valued. Recovery focuses on the question of how individuals' agency can be enhanced and stresses the importance of hope, responsibility, connectedness, peer support, meaning, and quality of life, not necessarily involving formal treatment (Leamy et al., 2011).

One of the first and most frequently cited definitions of recovery describes it as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life, even with any limitations caused by illness" (Anthony, 1993, p. 527). The recovery process is characterized by a search for a persons' strengths and capacities, satisfying and meaningful social roles, and mobilizing formal and informal support systems

(Slade, Amering & Oades, 2008). Recovery has begun to have an influence on thinking more broadly about mental health care and how social inclusion can be promoted (Thornton & Lucas, 2011). Still, the concept of recovery is not univocally understood by policy makers, service providers, service users and their families and various types of recovery are distinguished. 'Personal recovery' puts the subjective perspectives of service users and their lived experiences of mental illness at the forefront and accords well with the above-mentioned definition by Anthony (1993). 'Clinical recovery' refers to the absence of symptoms and cure of the disorder and is closely linked with how professionals and the community often define recovery. Other authors have discerned 'functional' and 'social recovery', as restoring one's physical, psychological and social functioning and regaining a valued position in society, respectively (Van der Stel, 2012). Personal recovery is considered to be the motor for these different types of recovery and an important objective in current mental health care (Leamy et al., 2011).

Research on recovery among offenders with mental illness remains scarce and has primarily focused on specific groups of offenders like drug and sexual offenders and persons in residential forensic settings. Available literature indicates that research on factors promoting personal recovery pathways among this population is particularly scant and most studies have measured relapse and reoccurrence of symptoms, applying a clinical approach to recovery. Research on personal recovery among offenders with mental illness showed that recovery is often accompanied by an additional process of 'offender recovery', as one has to rebuild a non-offender identity (Corlett & Miles, 2010; Drennan & Alred, 2014; Aga & Vanderplasschen, 2016). Consequently, recovery in this population is described as 'dual' or 'secure' recovery. Taking a new identity may consist of giving the offence and its context a place in one's life and restoring the harm and guilt caused by it (O'Sullivan et al., 2013; Ferrito et al., 2012). Based on a meta-synthesis of five qualitative studies about personal recovery in forensic settings, Shepherd and colleagues (2016) identified the need for protection and security, the importance of hope and social support and taking a new identity as prerequisites for personal recovery. The process of identity transformation includes several phases, and eventually contributes

to recovery (Olsson, Strand & Kristiansen, 2014). It can be concluded that the application of strengths-based approaches for supporting offenders with mental illness remains paradoxal, as recovery requires personal choice and social participation and support that are a priori limited in this population.

2.2.5. Criminology: Desistance

Since the early 1990s, interest in criminal careers has been increasingly reflected in criminological research. Although there is a longstanding tradition of criminal career studies, including exploring the onset and continuation of crime and recidivism, the study of desistance from crime is a more recent and increasingly important research area. Most scholars point to desistance as a process of moving toward desistance (in which reductions in offending are regarded as part of the process; Rodermond et al., 2016).

A large number of desistance studies focus on a broad population of offenders (Laub and Sampson 2003; Maruna 2001). There has been a growing interest in describing and understanding desistance in specific types of offenders, such as drug-dependent offenders and sex offenders (Colman and Vander Laenen 2012; Harris 2014; Göbbels, Ward and Willis 2012; Laws and Ward 2015). However, the existing knowledge on some subgroups of offenders is still scant, in particular regarding offenders with mental illness. More specifically, desistance research among persons who commit offences as an immediate consequence of their mental disorder is lacking (Göbbels, Thakker & Ward, 2016). A possible reason might relate to the fact that research on and interventions for offenders with mental illness are rooted in mental health care; while desistance originated from the criminal career tradition and is predominantly criminological (Colman and Vander Laenen 2012).

In 2004, Fergus McNeill made a strong case for including desistance in offender rehabilitation. Although his article was not focusing on offenders with mental illness, it does make clear that desistance adds two important elements to the discussion on treatment interventions.

First, from desistance research, it becomes clear that professional interventions and working relationships "*are neither the only nor the most important sources in promoting desistance*" (McNeill, 2004, p. 49). This does not entail a plea for a non-treatment paradigm. Rather it points to the need for a critical appraisal of the dominance of treatment interventions in offender rehabilitation. On a practice level, McNeill states that this does imply that professional intervention is "*in some sense, subservient to a wider process that belongs to the desister*" (McNeill, p. 46). We would take McNeill's argument one step further: if we really recognize the offender with a mental illness as a subject in his desistance process, the role and importance of professional interventions in the individual desistance process is to be acknowledged by the offender with mental illness.

Second, besides treatment interventions, other sources are (at least) equally important in promoting desistance. One can think of obvious sources such as personal strengths and capacities of the individual and of his/her social network. Fundamentally, what becomes clear from desistance research is that only focusing on individual and social network strengths and capacities does not suffice. In the desistance research and literature emphasis is put on the – structural barriers to - *opportunities* to exercise capacities (McNeill, 2006; Farrall, Shapland & Bottoms, 2010). It is not because a person wants to change and to desist that he or she will succeed. Structural constraints and barriers, for instance stigma or the lack of job opportunities for former prisoners/people with a mental illness, play a significant role and need to be tackled as well (Colman & Vander Laenen, 2012). These structural barriers specifically affect offenders with mental illness. For instance, one can think of multiple stigmas offenders with mental illness are confronted with and the lack of social networks or even the very restrictive (forensic mental health service and legal) conditions they face (Clarke, Lumbard, Sambrook & Kerr, 2016; Göbbels, Thakker & Ward, 2016; Arrigo, 2015).

In this respect, the recent article by Nugent and Schinkel (2016) is a very interesting contribution to the desistance literature. They distinguish between '*act-desistance'*, described as not committing offences, *'identity desistance'*, described as the creation of a new non-offending identity and *'relational desistance'* described as the recognition of change by society. They go on to distinguish relational desistance further into the individual's immediate social setting (micro-level), the wider community (meso-level) and the society as a whole (macro-level). While act desistance and identity desistance is something the individual can achieve, relational desistance involves other people. Nugent and Schinkel (2016, p. 14) end their article with the seemingly simple recommendation that we cannot place all of the responsibilities with the ex-offender and his/her social network; instead they argue "*a cognitive transformation about 'ex-offenders' is required within society*".

We conclude with the three elements that the desistance perspective adds to a strength-based approach of offenders with mental illness. First, in desistance (research), offenders with mental illness are central informants of what supports and hampers them in their desistance process and of how desistance could be defined (Polaschek, 2016). Agency, motivation and choice are essential elements of the desistance process (Maruna 2001). Central in the desistance perspective is respect for the autonomy of offenders (Ward, 2012b). This approach challenges a line of reasoning that questions the lack of readiness to treatment or (mental) capacities of offenders with mental illness. It questions the assumption that offenders should first be motivated to enter treatment as a necessary prerequisite for reducing recidivism, as desistance processes may initiate and develop apart from any formal treatment intervention.

Second, treatment interventions can be part of what is supporting desistance and in that case offenders with mental illness can give their experiences of what type of intervention (relation)

supports them in their desistance process.[1] They can also inform us beyond the mere desistance process on what constitutes a good life/ quality of life. It is clear that, when studying the desistance process of offenders with mental illness, sufficient attention has to be paid to both desistance of offending and recovery and to the complex interaction of desistance and recovery (Göbbels, Thakker & Ward, 2016; Colman & Vander Laenen, 2014). Yet, one important characteristic of desistance will always put a strain on the centrality of the individual in deciding on what constitutes his/her QOL in interventions. In desistance, the focus is ultimately on socially desirable outcomes (e.g. no/less illegal drug use, no criminal offences, employment) and less on client-reported outcomes and starting from clients' own expectations and experiences (e.g. quality of life) (De Maeyer, Vanderplasschen & Broekaert, 2009; Colman & Vander Laenen, 2012).

Finally, desistance moves the debate on the rehabilitation of offenders with mental illness beyond the individual (and social network) responsibility and the 'responsibilizing' of offenders with mental illness and includes the broader social and structural context into the debate (Fox, 2016). In particular for offenders with mental illness, changing the context to help people overcome the obstacles they face and welcoming them (back) into society (Bottoms & Shapland, 2011) is to be an essential and perhaps the most challenging element of a strength-based approach.

2.2.6. Special Needs Education: Quality of Life in forensic mental health services

In this section, we focus on Quality of Life as one of the concepts closely linked with strengths-based approaches, but – from an educational point of view – this should be embedded in a broader framework, including attention for, amongst others, context/milieu, uncertainty, flexibility, participation, inclusion, and human rights (Broekaert et al., 2004; De Schauwer et al., 2015).

[1] In this respect, McNeill links the person-centered, collaborative and 'client-driven' approaches by probation staff to the evolution of formal authority of the probation officer to a *legitimate* one in the mind of the offender.

The last decades, Quality of Life (QoL) has become an important focus in medical, social and (special needs) educational research and practice (De Maeyer et al., 2010). The QoL-concept has also been used in forensic mental health, albeit less frequently (e.g. Bouman, 2009; van Nieuwenhuizen et al., 2002; Pham & Salopé, 2013; Walker & Gudjonsson, 2000). According to Bouman (2009), QoL is important in forensic mental health treatment for two reasons. First, persons who have committed a criminal offence are human beings in the first place (cf. Ward, 2012a). As for everybody else, QoL is equally important for them. Secondly, objective factors related to QoL (e.g., poor financial situation, lack of social support, unemployment, no or limited participation in structured leisure activities, …) have been identified as risk factors in relation to criminal involvement and recidivism (Andrews & Bonta, 2010; Schel et al., 2015). Yet, contrary to these objective factors, the more subjective aspects of quality of life are not explicitly added to most currently available risk assessment procedures and instruments (Bouman, 2009). There is also a dearth of empirical studies investigating the relation between subjective wellbeing and risk assessment or criminal recidivism (Bouman, 2009, although some studies have tackled this relationship (Barendregt, 2015; Bouman et al.,, 2009; Draine & Solomon, 1994; Van Damme et al., 2016).

Already in 1994, Draine and Solomon investigated the relationship between the implementation of case management and recidivism in a sample of homeless offenders with mental illness. The results indicate that a lower quality of life was found amongst those offenders with mental illness who were mandated to return to jail due to breaking parole conditions within a six month-period after leaving the correctional facility. In a study by Bouman et al. (2009), the relation between subjective wellbeing and recidivism was investigated in a sample of forensic outpatients with personality disorders. Although there was no significant relationship between overall subjective well-being and self-reported recidivism after three months, two subdomains of subjective well-being, i.e. (1) satisfaction with health as well as (2) life fulfillment, proved to be negatively correlated with self-reported recidivism, also after controlling for risk level. With regard to official recidivism figures over

a 3-year period, the authors found a moderate negative relation between satisfaction with health and general subjective well-being with reconvictions for violent crime, but these relationships disappeared when risk level was added as a control variable. Barendregt (2015) (cf. *2.2.3.3.*) addressed the relationships between subjective quality of life and recidivism (measured 12 months after leaving the service) in a sample of male adolescents with severe psychiatric problems who were staying in secure residential care facilities. The results showed no association between subjective quality of life and self-reported delinquent behavior at the follow-up. There was, however, a relationship between subjective quality of life and psychosocial functioning (i.e., a lower quality of life led to more problems with regard to psychosocial functioning at the follow-up assessment). Van Damme (2016) investigated the relationship between Quality of Life and recidivism in a sample of adolescent girls with high rates of psychopathology who reside in a youth detention center. The study found no evidence for a direct relationship between Quality of Life and criminal offending; there was – however – an indirect relationship between Quality of Life, mental health problems, and recidivism.

As mentioned above, some pending questions with regard to the *operationalization, implementation and evaluation* of Quality of Life in the forensic mental health field were observed (van Nieuwenhuizen et al., 2002), especially when it relates to persons treated in residential services (Bouman, 2009; Schel et al., 2015). As most generic QoL-instruments entail indicators that are not (or hardly) applicable to persons who reside in closed institutions (e.g. with regard to mobility), assessing Quality of Life in forensic services is challenging. A measure that has specifically been developed in order to assess quality of life in forensic mental health settings is the Forensic Inpatient Quality of Life questionnaire (FQL) (Vorstenbosch et al., 2007). A recent study (Schel et al., 2015) using the FOL in two long-term secure forensic psychiatric services in the Netherlands, indicated differences between self- and proxy-based reports of Quality of Life. These results underscore the importance of involving different perspectives when assessing one's Quality of Life, and of paying enough attention

to the perception of forensic patients themselves. Interaction based on “real” dialogue between staff members and clients is an important challenge in this respect, which could be realized through the establishment of safe and “enabling” therapeutic environments (Fortune et al., 2014; Schel et al., 2015).

2.2.7. Family studies: social network and family strengths

Current social welfare policies are characterized by an increased appeal on family and social network members in supporting clients with diverse problems, including persons with chronic mental illnesses (Loukissa, 1995). In this respect, Bourdieu’s theory of ‘social capital’ makes clear that relations with social network and family members without mental illness are essential in empowering mentally ill persons to participate in society (Vander Laenen, 2011). However, it goes without saying that taking care of someone with a mental illness may impose a heavy burden on families and social network members in various domains of life (Lautenschlager et al., 2013; Marsh & Johnson, 1997).

Available research indicates that the accumulation of stress and burden on family members is even more concerning when the client has a forensic history in addition to his/her mental illness (Tsang et al., 2002). A recent review (Rowaert et al., 2016) has investigated the literature on the experiences of family members of offenders with mental illness. Besides mapping the needs and burden, the study also focused on exploring if and to what extent strengths were investigated and/or reported. The review showed that the number of articles focused on disclosing the experiences of family members is very limited, as only 8 studies were retained. The results further indicate, in line with the findings of Tsang et al. (2002), that family members are strongly affected by specific aspects that come along with having a family member with a mental illness who has committed a crime. These aspects include experiencing “dual” stigmatization (relating both to the mental illness as well to the criminal offence), coming across violence and being exposed to disengaging family and social relationships.

Further, exposure to the media and contact with police and justice are often reported. An important finding relates to the value that family members attach to contacts with professional care staff. In the reviewed studies, families reported these contacts as limited. None of the retained studies explicitly investigated strengths, although all of the articles referred to adaptive coping strategies. Yet, only one study (Nordström et al., 2006) referred to hope as a possible source for family strength (Rowaert et al., 2016).

The results of the study by Rowaert et al. (2016) accord well with literature in other criminal justice populations, showing that there is a there is a dearth of research on family experiences in general and strengths/protective factors in particular (Yoder & Ruch, 2015). In their study on involving family members of youth who have sexually offended, Yoder and Ruch (2015, pp. 2528-2529) addressed this issue and conclude: "*Risk frameworks identify family as part of the problem, consequently discouraging engagement and producing intermittent involvement. As professionals begin to endorse a strengths-based approach to assessment with families and youth, whereby a holistic and balanced perspective is established even before engagement (Nickerson et al. 2004), reformed engagement and practice ideologies can similarly consider families as part of the solution.*"

3. Dilemmas and challenges in applying strengths-based approaches

3.1. "Living apart together": the integration of different disciplines

Working with offenders with a mental illness relates to a variety of disciplines that are entangled, but yet very different in many aspects. An important finding of the review is that each of these fields has witnessed a paradigm shift in how offenders are being looked at. Instead of focusing on one's "deficits", incapacities or problems, strengths-based approaches are grounded in a more positive view on humankind: everybody has capacities and society at large plays an important role in enabling persons to use and develop these possibilities (Fox, 2016). From that point of view, the 'divides' between the different disciplines are narrowed (but they did not disappear, which should, in our

opinion, not happen as well, cf. intra). This also means that the focus on strengths should not be ("merely") used in an instrumental way (e.g. merely improving one's Quality of Life to reduce recidivism) but considering this attention for capacities as a fundamental right of everyone (Bouman, 2009; Ward, 2012a). Rather than looking at improving QoL and reducing risk as two different goals, we concur with the assumptions of the Good Lives Model in which these objectives are tackled in an integrative manner (Ward & Brown, 2004). Yet, this does not mean that different disciplines are simply '*saying the same things in different words*', let alone that they are pursuing the same goals. A fundamental difference (which should be preserved and made explicit) relates to the different objectives of each of these disciplines (cf. Barnao & Ward, 2015; Vander Laenen, 2014). This is especially the case when working across the care-control divide. In this sense, we consider different disciplines as partners "*living apart together*" (Van Cauwenberghe, 1994).

With regard to strengths-based interventions for persons with mental illness, Tse et al. (2016, p. 291) refer to "*Taylor (2006) [who] strongly cautioned against using only a strength-based approach completely isolated for medical treatment approaches*". In our opinion, the same holds true when applying strengths-based approaches with and for offenders with mental illness without using risk-management models and mental health perspectives. This does not mean that models are to be used eclectically or in 'hybrid' form as it is labelled by Barnao & Ward (2015); rather it refers to integration as described by Broekaert et al. (2004, p. 2013): *"The competing paradigms [one could say disciplines – added by the authors] alternatively complement each other (…). The dynamic and interdependent transactions between different positions can be seen as an inaccessible synthesis, which in its turn includes its own antithesis and a new move towards synthesis."* This integrative stance departs from uncertainty and doubt: "improvement", rather than curing a defect/disease/illness/disorder and/or eliminating criminal behaviour as such (Broekaert et al., 2004). Gaining insight in what improvement means is not defined by clear or objective standards. In our opinion, the dialectical transaction/dialogue between all actors in their daily interactions may shed light on what constitutes improvement (one could say: a "good life" in terms of the GLM) for each and every individual.

3.2. "Beyond Babylonian confusion and towards more theoretical research": conceptualization of strengths-based practices in different fields

Different disciplines use different terms and concepts in order to denote the strengths-based approach: 'good lives', quality of life, procedural justice, human rights, strengths, capacities, and protective factors are only some of the keywords that are used in relation to strengths-based practices. Interrelations between some of these concepts are quite well elaborated (e.g. between recovery and quality of life, cf. Cherner et al., 2014 and recently between recovery and desistance, cf. Best, in press) or have already been reported in some studies (e.g. between procedural justice and recovery, cf. Donelly et al., 2011; Kopelovich et al., 2013); while – surprisingly – other links have been not yet or only scantly studied (e.g. between QoL and desistance, cf. Colman & Vander Laenen, 2012). More research exploring the similarities and differences between these concepts is needed, in order to prevent 'loose' definitions and operationalization as has already been mentioned as a critique on the strengths-based approach in general (Rapp et al., 2005). A particularly relevant and interesting topic relates to the links and differences between Quality of Life and a 'good life' as used in the GLM (Ward & Brown, 2004). As a "good life" entails an important normative aspect, i.e. securing primary goods in a non-criminal way, the relations with Quality of Life, and its objective and subjective aspects should further be scrutinized (Decoene & Vandevelde, 2016). As mentioned by Ward and Brown (2004), the primary goods discerned in the GLM relate to the QoL-concept and its domains/indicators, but are not synonyms. In the field of youth forensic psychiatry, Barendregt et al. (2012) have developed a comprehensive model in which the GLM and Quality of Life have been explicitly linked, starting from a life course perspective in order to account for persisting criminal behaviour. This relates well to current work undertaken by Ward & Fortune (2016) in order to discern the causes of criminal behaviour and the role of dynamic risk factors herein. In this paper, a number of problems with viewing dynamic risk factors as causes rather than as predictors are listed that affect all of the current forensic rehabilitation models. Ward & Fortune (2016, p. 88) make a plea for 'deconstructing' risk into explanatory and causal aspects, based on theoretical analysis: "*simply*

stating that a theory is "strength based" does not address the issues of incoherence, specificity, reference, and inappropriate explanatory targets (…)". We might add that the same holds true for 'protective' factors.

3.3. "No agency without autonomy": the individual in context

Strenghts-based approaches, including the GLM, draw on the psychological theory of self-determination, developed by Deci and Ryan (2008). This model states that persons flourish if the following basic human needs are met: autonomy, relatedness and competence. Attention to these basic needs in forensic treatment may be hindered by the fact that people are often still being "*blamed*" for committing crimes (Bremer, 1989 as cited in Yoder and Ruch, 2015, p. 2528) and/or for having mental health problems. As outlined before, this refers to the importance of the role of (therapeutic) relationships and human interaction. Autonomy is not something that is inherent to a person, rather it takes form in relation to other people. The dilemma of focusing on agency in persons who are often described as subjected to a measure of 'legal insanity' or who are labelled as not being responsible for their (criminal) acts particularly comes to the fore in treatment. Not only may treatment (at least temporarily) limit one's agency/autonomy and possibilities to acquire human needs (e.g. because he or she is mandated to care) (Barnao et al., 2010), a too narrow focus on treatment in relation to desistance and recovery may overlook the role of contextual factors and society at large. This surpasses "blaming" the individual and focuses on societal factors that play a crucial role in providing opportunities for people to become "inclusive citizens" (again) (Lister, 2007). It also refers to the importance of really being listened to and start from what people indicate as being the 'driving forces'/priorities in their life (Ward et al., 2007).

3.4. *"Risks, strengths and capabilities": the search for an integrated paradigm*

An important question relates to the definition and place of strengths / protective factors in relation to dynamic risk factors. In line with the GLM (Ward & Gannon, 2006), assessment of an individual's strengths and difficulties should start from a holistic point of view. Broekaert et al. (2004) refer to

this as the continuous interaction between parts and totality. This is further exemplified in the fact that recovery/desistance is really grounded in daily life and all aspects that constitute this, i.e., personal, contextual and societal strengths and challenges (Nugent & Schinkel, 2016). This was already acknowledged in 1977 by the Dutch pedagogue Ter Horst, who wrote a well-known book on recovery (the book was entitled "*Recovery/restoration of the daily/ordinary life*" –translation by the authors). In his vision, recovery is not limited to a stage in a treatment process but to the restoration of daily life. Consequently, attention has to be paid first to staff members (educators) and to their state of being. If they do not have the right attitude for education or when they e.g. suffer from burn-out, they will disturb the whole recovery process or block the road to recovery. With regard to the clients, the following aspects, amongst others, are mentioned (notice the resemblances with what we currently label as human needs/primary goods): Is the person physically fit? Does he/she feel safe? Is attention paid to his/her identity? Is the person emotionally open enough? Is the person able to touch (hug), to care for, to be playful? To discover? To work? To learn? To dialogue? To engage in festivities and rituals? To live in the here and now and to explore his/her past? Is attention for the suitability, complexity and structuring of his environment present ? And for the reality behind the created environment (Ter Horst, 1977). In conclusion: If considering strengths-based approaches when working with people in vulnerable situations (in this case offenders with mental illness), "improvement" relates to client, staff, the daily reality and all of the processes '*behind the scenes*' of the outside, observable, world.

4. Conclusion

The aim of this review relates to what Ward (*this issue*) identified as the risk of not critically reflecting on what is commonly labeled as strengths, resilience, or protective factors. Based on the findings of this review, we are strong proponents of a genuine shift in how 'offenders' are viewed, explicitly starting from an abilities-oriented instead of a deficit-oriented point of view. Besides this basic view on humankind, different disciplines also share the focus on fully respecting the autonomy and agency

in the interaction with people who have offended. Yet, differences still apply to the objectives that the different disciplines strive for which indicates the importance of not universally viewing strengths-based approaches working in each of the disciplines as 'being small variations of the same theme'.

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