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Mckeown, Michael ORCID: 0000-0003-0235-1923 and Spandler, Helen ORCID: 0000-0002-0970-5141 (2017) Exploring the Case for Truth and Reconciliation in Mental Health Services. Mental Health Review Journal, 22 (2). pp. 83-94. ISSN 1361-9322

It is advisable to refer to the publisher's version if you intend to cite from the work.

<http://dx.doi.org/10.1108/MHRJ-01-2017-0011>

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Exploring the Case for Truth and Reconciliation in Mental Health Services

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Accepted for publication *Mental Health Review Journal*

Introduction

This paper explores the case for organising a reparative truth and reconciliation (T&R) process in mental health services and systems. For the purposes of this paper, we refer to 'psychiatry' and 'mental health services' interchangeably as a whole set of related practices in which mental health professionals are involved. This includes the medical speciality of psychiatry which is the dominant perspective in mental health services and frames statutory mental health systems. T&R would involve bringing together service users, survivors and refusers of services, with the staff who work/ed in them, to begin the work of healing the hurtful effects of experiences in the system (Slade 2009; Wallcraft and Shulkes 2012; Spandler 2016b; Mckeown 2016). We see this as part of a wider project concerned with challenging, reforming and transforming mental health care. In the absence of any officially sanctioned Truth and Reconciliation (T&R) process, we outline a grassroots initiative which could bridge towards constructive alliances between workers, service users and survivors.

We have been involved in various mental health movements, predominantly as allies of psychiatric survivors/service users, and have reflected upon the value of such conjoint activism (e.g. Cresswell and Spandler 2013; McKeown et al. 2014).

However, we have been frustrated with tendencies for polarisation and splitting which can derail progress by oversimplifying complexity, stifling debate, and preventing further exploration and mutual understanding of different perspectives.

For alliances to embody genuine solidarity, rather than temporary instrumentality (for example defending services, which may be inadequate, or even harmful), we need a way to heal prior damage and provide restitution. It has recently been argued that the neoliberal retreat from service provision has inadvertently opened up potential

spaces for grassroots activists to engage in reconciliation processes (Inwood et al. 2016). This doesn't mean that neoliberalism (or, for that matter, psychiatry) shouldn't be contested, but that the possibility for its transformation may lie in opportunities to articulate innovative strategies to achieve social justice. For example, by daring to 're-fashion and re-imagine' possibilities for more just and peaceful social relations (or support and services) (ibid: 59). In the process, this might expand our ideas of what peaceful societies (or mental health services) might look like.

We recognise that our proposition for a T&R process in psychiatry is contestable. On the one hand, some may see it as unnecessary, others as merely reforming a harmful system that should be abolished. Ideally, the process would include people who wish to defend or reform psychiatry as well as those who seek to abolish it, as long as both are willing to listen to other's experiences and perspectives. Ultimately, we argue that if enacted with due care and sensitivity, the process could actually prefigure the kinds of social relations required to frame better or alternative mental health care.

What is Truth & Reconciliation?

Truth and reconciliation approaches have been enacted with varying degrees of success in nations afflicted by human rights abuses or civil wars. The archetypal South African Truth and Reconciliation Commission (TRC) was convened to address national healing following the abuses of apartheid (Clark 2012; Rose 2015).

Democratic nation-building was to be supported by an explicit embrace of restorative rather than retributive justice, providing amnesty for perpetrators and reparations for victims. The architects of the TRC were animated by 'the importance of bearing witness to the past', seeking reconciliation through public apologies, 'truth-telling and forgiveness' (Stein et al 2008: 463).

In the absence of public apologies for psychiatric wrongdoing and the continuation of a contested psychiatry in the present, grassroots T&R initiatives may be more relevant to our purposes. For example, in recent years there have been a number of 'bottom-up' reconciliation initiatives in the US set up by community organisations without local or national government endorsement (Androff 2010; Inwood et al.

2012). These constitute promising models for other communities seeking processes of reconciliation (Androff 2010) and, as we shall see, have begun to be adopted in the psychiatric context.

T&R processes are a form of 'transitional' justice aimed at forging newly respectful relations and restitution for harm and wrongdoing. These are based on an optimistic view of human relationships and belief that social change is possible (Seidel & Abu-Nimer 2015). They differ from victim-offender restorative interventions as they operate at a community level (Androff 2010). T&R involves, but is not confined to, the public expression and acknowledgement of the testimony of previously silenced and oppressed groups. This can promote greater compassion and community, raise collective consciousness, provide accountability and promote healing (Rose 2015). For example, the public expression of private pain can 'transform the personal experiences of victims into a far deeper statement of collective suffering and injustice' (Rose 2015: 71).

There are limitations to T&R which we explore, with specific reference to psychiatry and mental health services in a later section. More generally, participating in T&R isn't always immediately helpful and the inherent therapeutic value of revealing traumatic experiences has been questioned (Rose 2015). For example, revisiting these can amplify distress and further expose or violate victims (Stein et al 2008). In addition, there may be pressure on survivors to 'forgive' and disappointment with slow pace of change or lack of compensatory measures (Jeffery 2015). McEvoy and McConnachie (2013) also highlight the centrality of attributing blame and victimhood, which might not always be helpful. Positive benefits have often been distributed at the community or nationhood levels, promoting collective reconciliation or acceptance, largely amongst citizens witnessing the proceedings, rather than through personal testimony (Stein 2008). Therefore reconciliation processes should carefully and sensitively deal with matters of testimony, for example by not necessarily *requiring* disclosure of victimhood or interpersonal forgiveness, but rather work towards more peaceful relationships in the present and future (Rose 2015).

Moreover, T&R processes can move beyond testimony and truth-telling to involve a reciprocal commitment to critical self-reflection, cognisant of the complexities of the

distribution of harms, both between and within groups. In effect, there is a concomitant need to critically reflect upon all aspects of harm and possibilities that victimhood may not always be a one-way street (McEvoy and McConnachie 2013). As a result, one of the most significant achievements of the South African TRC was in emphasising a common humanity and cultivating a deep sense of empathy, helping to promote a more compassionate collective consciousness (Rose 2015) and process of 're-humanization' (Androff 2010: 274).

It is claimed that TRCs have 'proven to be malleable enough interventions to be adaptable to a range of unique contexts' (Androff 2010: 272). Arguably, T&R processes might help redeem health care organisations afflicted by catastrophic system failures such as at Mid Staffs Hospital (Francis 2013) and Winterbourne View (DoH 2012). Indeed, the 'human factors' movement urges the NHS to adopt no-blame investigation of service failings, encouraging openness and disclosure rather than evasion and reticence (Bromiley 2009). With this in mind, it seems reasonable that T&R could be utilised in the psychiatric context. First, however, we need to provide justification for this.

Psychiatric harm

The case for truth and reconciliation is most evidently grounded in a litany of harms experienced by users or 'survivors' of mental health services. Obvious historical examples include: "lobotomies, incarceration, seclusion, and restraint, harmful drugging and electroshock, and stigmatising diagnoses meted out to people of particular 'race', gender and sexuality" (Wallcraft & Shulkes: 2012: 12). As these authors note, such practices continue within contemporary psychiatry in one form or another. If anything, the relative dominance of a singular bio-psychiatry has been consolidated, despite rhetorical commitments to biopsychosocial approaches (Read 2005). Arguably, this continues to allow for forms of psychosurgery and other physical treatments experienced as harmful (Johnson 2009). In addition, the propensity of psychiatry for colonising expansion, whilst neglecting survivor perspectives, is evident in ongoing controversies surrounding psychiatric assertions that conditions like Myalgic Encephalopathy/Chronic Fatigue Syndrome (ME/CFS) constitute 'false illness beliefs' (Blease et al 2016; Spandler 2016b). Arguably,

systematic refusal to attend to users and survivors experiential knowledge - 'epistemic injustice' - might be a specific form of psychiatric harm (Crichton et al 2016; Liegghio 2013)

Mental health services can be traumatising and re-traumatising, even being referred to as 'trauma-organised systems' (Bloom & Farragher, 2010; Sweeney et al 2016). Widespread practices including physical restraint, seclusion and forced medication are most obviously implicated (Freuh *et al.*, 2005), but more subtle coercions occur which inflict or revisit experiences of powerlessness, such as restrictions on liberties or discursive pressure to comply with treatment (Bloom & Farragher, 2010). Indeed service users and their allies have long criticised over-reliance on medication which has a disputed evidence base and can cause serious, long-term detriments (Whitaker 2002; Moncrieff 2013). These kinds of negative experiences have led many critics to see psychiatric treatment as 'iatrogenesis' (Breggin 1991).

The harmful effects of mental health systems are especially concerning given the increasing evidence of links between childhood abuse and mental health problems (Varese et al. 2012). Moreover, there is evidence that patients have been sexually and physically abused within services, especially in-patient settings (Henderson & Reveley 1996); with patients reporting abuse disbelieved, pathologized and silenced (Jennings 2016, Masson 1988). More than this, reactions to abuse are often reframed as symptoms of mental illness, especially 'borderline personality disorder' (Asylum magazine 2004). Even when disclosure occurs, and is believed, proportionately low numbers of service users receive appropriately formulated or compassionate care (Read et al 2016; Sweeney et al. 2016).

Hurting the workforce too

Once a case has begun to be made for truth and reconciliation within mental health services we can also recognise that staff are damaged in the system. This can be related to the stresses of working within inadequately resourced or managed public services, anxieties over adverse outcomes for service users, threats of violence, and the possibility of vicarious trauma within a caring role. In addition, staff who blow the whistle on inadequate care or organisational wrongdoing have been victimised by

employers and colleagues (Jackson et al. 2014). Even if not a prime reason for entering into T&R, acknowledgement of staff hurt opens up possibilities of also attending to this and seeking common cause in addressing the complex distribution of harms. Of course, many staff in mental health services also experience mental health difficulties or use services themselves, problematising any simple demarcations of identity. In other words, categories of 'service user' and 'mental health professional' frequently overlap.

Rates of workplace stress and mental health problems are high in the mental health-care workforce with consistently high sickness/absence rates (Rossler 2012; The UK Health and Safety Executive 2016). In addition, research has noted the potential for a distressing impact upon mental health professionals working with traumatised individuals; indeed, the more empathic practitioners may be even more vulnerable (Figley 1995; Sabin-Farrell and Turpin 2003). These deleterious effects are reflected in the lexicon of compassion fatigue, vicarious trauma and secondary trauma and are complicated and compounded by wider structural factors.

Given the legitimacy afforded to compulsion and coercion within psychiatry, practitioners are inescapably complicit in interventions survivors might view as harmful, even if they may object to them or be reluctant to use such measures like physical restraint. Workers may bear responsibility for quite serious consequences without necessarily having sufficient authority to alter systemic practices or overarching power relations (McKeown and Foley 2015). Most members of the mental health workforce would plausibly deny they entered into this work wishing to abuse, harm or dominate.

Therefore, whilst conflictual relationships are highlighted as a major source of workplace stress (Rossler 2012; Unison 2014) these are perhaps best viewed as complex rather than simply oppositional. However, cycles of reciprocal traumatisation can emerge as service users' fear or powerlessness precipitate aggression towards staff who, in turn, become suspicious and antagonistic, further justifying coercive and containing organisational responses that escalate service users' safety concerns and provoke yet more aggression (McKeown et al. 2017). T&R processes may justifiably help in careful consideration of the complexities of

relations between staff and service users to help explicate certain propensities for mistrust, violence and coercion on all sides (Bloom 2006, Sweeney et al 2016).

Truth and reconciliation in the psychiatric context

We are by no means the first to suggest a truth and reconciliation process in the context of mental health services. Previous calls for T&R have usually focused on demanding public apologies. For example, Mike Slade (2009), a pioneer of the recovery agenda, raised this possibility, followed by calls from the survivor movement in the UK (Wallcraft 2010) and the US (Harris 2014). Slade (2009) locates concerns over psychiatric harms within a broader socio-political frame, arguing the first step towards genuine partnerships in mental health should be a public apology for the wrongs done in the name of care and treatment. This, he argues, is justified when any dominant group inflicts harm on a subordinate group over a sustained period:

‘Real reconciliation ... may only be possible once a line has been drawn, through the symbolism of an apology, which explicitly recognises the need for a new trajectory in the future’ (Slade 2009: 73).

Whilst psychiatrists have engaged in T&R processes, this has usually been as expert witnesses in relation to the suffering experienced by indigenous populations under various colonisation regimes, rather than addressing psychiatry itself (e.g. Cox 2005). Slade (2009: 73) notes ‘no general apology for maltreatment ... has ever been made by a government or a mental health professional body’. The few extant psychiatric apologies have focused strictly on narrow and clear-cut abuses of earlier generations of professionals. Notable examples include the President of the German Association for Psychiatry and Psychotherapy apologising for psychiatrists’ complicity during the Nazi regime’s forced sterilisation and murder of psychiatric patients (Wallcraft & Shulkes: 2012: 12-13).

More recently, the New Zealand government specifically apologised for inappropriate treatments such as ECT and injections being given to children and young people at Lake Alice Hospital in the 1970’s. Following this, a series of further complaints were

made by former patients across the country, calling for a process of redress. This resulted in the government setting up a Confidential Forum in 2005 to hear former in-patients (as well as family members and staff) accounts of their experiences within psychiatric institutions before 1992, when current mental health legislation came into effect (Department of Internal Affairs 2007). Whilst a step towards recognising harms, it was criticised by some patient groups for not resulting in a general public apology and still being limited to historic cases of maltreatment (Kavanagh-Hall 2013). Entering the realms of satire, the celebrated antipodean survivor Mary O'Hagan refers to a successful international truth and reconciliation commission for psychiatry in a mock radio interview 'taking place' in 2031-2033, precipitating a 'cascade of apologies' and reforms (<https://www.youtube.com/watch?v=T1e1trJhs2g>).

In the UK in 2010 Jan Wallcraft, psychiatric survivor, scholar and activist, started a Truth and Reconciliation in Psychiatry petition with accompanying draft statement: http://www.ipetitions.com/petition/truth_and_reconciliation_in_psychiatry/. Citing Slade's call, Wallcraft drew on the ratification of the UN Convention of the Rights of Persons with Disabilities (CRPD) to demand apologies from government and professional bodies. The Convention has been seen as a major step advancing the rights of people with psychosocial disabilities, declaring enforced psychiatry a human rights violation (Minkowitz 2015). The required apology, it was argued, should be negotiated internationally and accompanied with the 'right to reparation'. The latter included specific demands for service user defined and non-coercive services, such as the Soteria model and service user-led crisis houses, and repealing all discriminatory forced treatment legislation, with due regard to the CRPD. Similarly, in the Canadian context, the survivor magazine Our Voice/Notre Voix had a front page feature calling for a long overdue public apology from psychiatry (LeBlanc 2016)

In addition, in the absence of formal public apologies, some grassroots organisations have begun to explore 'bottom-up', transitional forms of justice, starting the process of reconciliation themselves by exploring various ways of acknowledging harm and discussing difficult and divisive issues in the present. The following section outlines a recent notable example.

Communicative processes in reconciliation

One of the most important aspects of T&R is the creation of new spaces for conversations, listening and dialogue, outside the parameters of the regime under question (in this case psychiatry):

‘One of the first keys in justice activism is getting participants to sit down with one another to engage fully in a process that can create the conditions necessary to organising work to occur’ (Inwood et al 2016: 59)

In 2016, three grassroots mental health organizations in the US, The M.O.M.S. Movement, Rethinking Psychiatry and The Icarus Project hosted a series of T&R events. These events were initiated primarily in response to many users and survivors experiences of dissatisfaction and harm within mental health systems (Levy 2016a;b). They adopted the practice of ‘healing circles’ which have been used in other community-based restorative justice initiatives (Androff 2010).

The healing circle approach involved creating inner and outer circles of participants identifying with particular constituencies, e.g. staff or user/survivor, who take turns to respectfully listen to each others’ narratives without interruption, before periods of questioning for clarification and discussion. The space created is intended to enable silenced voices, and stories of harm, that aren’t usually heard, to be aired, acknowledged and attended to. Whilst it was set up because so many people feel traumatised by the dominant psychiatric model, there was also room for people who feel it had helped them. In addition, whilst the primary focus was of the experience of people who felt harmed by mental health systems, it could also include people who feel harmed by people with mental health problems, whose stories aren’t heard either – except as stories of the ‘dangerous mentally ill’. Participants seemed to appreciate the opportunity to be heard and engage in genuine dialogue. For example, staff who attended the first event reported it had already changed how they practiced e.g. instead of giving the ‘party line’ about medication (“it’s like insulin for diabetes”), they felt able to be more honest and offer balanced information. Whilst these may be small steps, they point to possibilities for more significant shifts over time.

This initiative included someone who had been involved in the original South African T&R process. Inspiration was gleaned from work with other politically divisive topics where protagonists seemed to have little in common (e.g. abortion, LGBT rights). The organisers were also inspired by features of the Open Dialogue approach to mental health care (Seikkula & Arnkil 2013). One of the core principles of open dialogue is commitment to speak honestly with the person's self identified social network present; in effect, mirroring the truth-telling of reconciliation processes. Open Dialogue draws upon Mikhail Bakhtin's theories of polyphonic dialogic communication (Seikkula & Olson 2003). Bakhtin's ideas offer a way into thinking about the organisation of truth and reconciliation hearings and potential experiences within them: the 'understandings' reached may not belong to any individuals, rather being collectively constructed through concerted attention over the course of the proceedings. Culturally, such respect and attention to the experiences and viewpoints of others may be fairly untypical. To paraphrase Ptery Lieght (KBOO 2016), the inability to dialogue creates dis-ease.

Objections to T&R in mental health systems

A number of complicating factors problematise any simple adoption of T&R in the psychiatric and mental health context. Therefore, in this section we respond to four potential objections. We address them directly, in turn.

1. What if psychiatry won't accept wrongdoing and apologise?

T&R processes are usually developed where wrongdoings are historical and there is public acknowledgment of abuse and acceptance of the need for restitution. As we have seen, there has been no general public acknowledgement or acceptance by psychiatry of wrongdoing and critics argue that abuses are not 'historical' and continue to this day (e.g. Virden 2016). Thus, some have argued that that any psychiatric apologies for crimes and mistreatment in the past would be self serving because 'the legacy of previous abuses *continues* in the cruel and unacceptable treatment of people all over the world (Wallcraft & Shulkes: 2012: 12-13 emphasis added). Similarly, LeBlanc argues that states resist apologising lest it undermine the

'flawed speciality of psychiatry' (2016: 62). If the psy-professions are unwilling to recognise wrongdoing and apologise this makes an official T&R process difficult to establish.

However, T&R does not have to rely on public apologies, important though they are, but can be an important first step towards the wider *recognition* of psychiatric harm. Any T&R process involves gathering multiple testimonies from users/survivors which have to be heard without judgment, argument or contestation. Robert Miller (2012) who helped initiate an ongoing process of reconciliation following the New Zealand Confidential Inquiry noted that understanding what went wrong, and publicly acknowledging it, may be the biggest step to reconciliation, and the strongest safeguard against its being repeated.

Moreover, it is often precisely the absence of formal apologies that has inspired activists to utilise T&R in grassroots initiatives connected with demands for social change (see Androff 2010; Inwood et al 2016). Indeed, such grassroots T&R usually follow a period of community activism where it became increasingly clear that relevant authorities were unwilling to take reparative action (Inwood et al, 2016). In addition, there might be benefits to grassroots initiatives as they are not subject to restrictions, limitations and parameters set by state-funded reparation schemes (Rose 2015). On the other hand, grassroots initiatives may lack the 'teeth' to actually provide restitution or compensatory measures (Inwood et al 2016).

2. Surely psychiatric harm isn't equivalent to other human rights abuses?

The call for psychiatric T&R appears to rest on analogy with other human rights abuses, such as genocide or apartheid. Critics may question whether such comparison is appropriate. After all, psychiatry is complex and not 'monolithic and hegemonic' and this complicates the case for a singular oppressive regime (Rose 2016: 434). Despite the efforts of radical survivor groups, it has not been universally established or accepted that psychiatry is inherently abusive, wrong or blameworthy. Ultimately, psychiatry remains contested and contestable. In addition, whilst many mental health services are framed by psychiatry their practices may vary considerably. It is not the case that all survivors reject all aspects of psychiatric

systems, including even compulsion and coercion, which some argue cannot be simply reduced to human rights violations (Katsakou et al. 2012; Plumb 2015). For example, some service users and their families argue, in hindsight, that despite the oppressive nature of hospital wards and the lack of support offered, they might have actually preferred *more* intervention, for example, to prevent absconson when severely depressed or suicidal (e.g. Poursanidou 2013). Indeed, even though psychiatric abuse is still concerning, perhaps in the current context challenging psychiatric *neglect*, rather than *abuse*, might be more appropriate (Spandler 2016a).

Whether or not psychiatric harm is 'equivalent' to other human rights abuses, a good enough case has been made that mental health services can be harmful and trauma-reinforcing, both historically and in the present (Sweeney et al. 2016). There is also an argument for specific psychiatric 'epistemic' injustices or violence, where mental health service users are systematically denied opportunities to have their own experiential knowledge accepted and valued (Liegghio 2013). Indeed, one of the criticisms of formal T&R processes is that it too narrowly focuses on particular instances of gross human rights violations, and hasn't addressed more subtle, yet still damaging, systemic relations (Rose 2015). This recognition lies behind the recent T&R movement in the US which seeks to address a wider range of issues such as structural racism and inequality (Inwood 2012).

The time may come when there is widespread acceptance and condemnation of psychiatric harm, perhaps with recourse to the UN Convention. In the meantime, T&R processes can begin the work of demarcating boundaries between 'conflicts', between different groups about how to respond to mental distress, and 'abuse', involving systematic abuses of power (Shulman 2016). Perhaps healing or restitution cannot take place until the full extent of survivor grievances have been acknowledged.

3. Won't calls for Truth and Reconciliation alienate mental health professionals and workers?

Partly as a result of these complications, many workers may be reluctant to take part in a process which makes parallels between their professional role and perpetrators

of significant human rights abuses. Arguably, calls for T&R could alienate workers, who might feel attacked and defensive, as well as some service users who don't recognise their experiences as abusive. This is especially the case if the analysis of harm depicts psychiatric services as a totalising 'system' and this becomes an *ad hominem* argument when it further implies professionals are 'actually nasty people' (Rose 2016: 435). Whilst psy professionals may have certain powers they usually exercise them with reluctance, caution and some cynicism (*ibid*).

We have previously made the case for greater alliances between relevant trade unions and radical survivor movements. Yet trade union involvement in T&R is potentially contentious because of their chequered history in prioritising defending 'jobs and services' over contesting practices and unequal power relationships within services. It is notable that unions' broader international positions, for instance supporting T&R in South Africa, don't necessarily translate into more reflexive attention to their own members' working practices in psychiatric services. For example, unions and management have typically collaborated on 'zero tolerance' policies which minimise consideration of the various structural and systemic factors that might precipitate violence. Furthermore, at least some of the violence in psychiatric services is enacted by service users who wish to resist the implicit and explicit coercive aspects of the system, including enforced treatment such as intramuscular medication (McKeown et al 2017).

Clearly, addressing the violence of all parties, the implicit violence of the system, and how this is legitimated, could be a key focus of any truth and reconciliation process. T&R processes might help unpack complexities in the distribution of harms, taking on board staff sensibilities and responsibilities. Amongst these concerns is the potential to see mental health staff as damaged by the system they work in, acknowledging their experiences too. Associated with this recognition is consideration of the extent to which all individuals or elements of the workforce are equally complicit, culpable or accountable for harms experienced by service users.

T&R processes could assist workers (and service users) to appreciate and understand power imbalances in more nuanced ways. In turn, this may help staff engage with radical survivor critiques without feeling personally or unfairly attacked,

and critically reflect on their own discomforts and responsibilities within the system they work in (McKeown & White 2015). Whilst T&R processes might also help to acknowledge staff, as well as user/survivor hurts, significant power imbalances between users and staff must always be kept in mind.

4. Shouldn't inadequate mental health services be challenged through political activism?

Finally, some critics may argue that change will be achieved through social action rather than the more 'therapeutic' focus of T&R. This objection is linked to various 'structural critiques' of transitional justice that suggest focusing on individual testimonies doesn't sufficiently address social inequalities and structural violence. In other words, attempts at healing without changing the underlying socio-political conditions is inadequate and ineffectual, it merely 'pacifies' or 'placates' rather than delivers genuine justice (Nagy 2012). Indeed truth sharing alone does not bring about transformation; it might equally be 'helpful, harmful or irrelevant', and other factors or strategies need to be considered (Mendeloff 2004). Many radical survivors might be reluctant to participate in T&R initiatives, mistrusting the sincerity of worker participation or suspecting that a disliked biological psychiatry might emerge intact, or even bolstered, after a superficial or insincere baring of its soul.

This kind of 'structural critique' relates to a broader false dichotomy between peace and justice, or transitional and transformative justice (Rose 2015). It is true that reconciliation is an ongoing process that cannot be achieved merely through T&R processes, and ultimately depends on a range of other factors (Rose 2015). Its goals may be 'modest' but they are still highly significant (ibid 68). T&R should not be a replacement for wider social change and it is not a panacea. Arguably T&R should be *part of*, and not separate from, a wider transformatory project. Moreover, the case for grassroots T&R requires the active involvement of grassroots organisations and the building of progressive coalitions (Inwood 2012). Therefore, they are not two opposing or mutually exclusive strategies. Indeed, it might even be argued that wider change cannot be achieved unless we pay attention to these more nuanced discussions. In other words, T&R processes might actually help inform activist strategies making them more effective in the long run.

Structural change necessitates and depends upon changes in our understanding and ways of thinking. Therefore, the dialogical potential of a grassroots TRC provides opportunities for bottom-up transformation grounded in the practical, concrete and hard fought realities of struggle (Inwood et al. 2016). In order for progressive change to happen, perhaps radical social movements, *as well as* mental health services, need to be more open minded, reflexive and critical. There is no point in making grand statements about what we want to achieve without paying attention to the means of achieving this. If we don't develop better ways of discussing and debating together we may merely reproduce old problems in any new mental health systems. That means being open to new ways of working together and resolving conflict without personal attacks, insults and blame. In other words, it would be hypocritical to criticise psychiatry for being coercive, abusive and non-consensual if we can't develop consensual, equal and respectful relationships with those we disagree with.

Our case for deploying truth and reconciliation could be part of a broader agenda for progressive change which acknowledges prevailing and historical harms are a profound impediment to alliances between service users, survivors and the workforce. Arguably, we cannot realise genuine solidarity without the precondition of acknowledging harms. This is about inviting various actors, regardless of starting positions, into a space where grievances can be aired, listened to, understood, and restoratively acted upon. Rather than an end in itself, this could be a necessary first step on a journey of *continued* dialogue and action.

Whilst these processes might be healing, it is important they are not imposed on people, seen as part of 'treatment', or co-opted by professional groups. Activists have made it clear reparation must not be subsumed under a clinical mindset, avoiding temptations to pathologise user and survivor complaints. As Flick Grey (2017) wryly notes "how quickly our mental health professional "colleagues" adopt a clinical gaze when faced with challenging thinking or emotional distress from mad folk!" Finally, any T&R process needs to be actively supported by those communities most affected by the conflict, in this case survivor/service user groups.

Conclusion

If our case for T&R is accepted, the obvious question is: what next? The first thing to say is that T&R processes must be adapted to context, not just taken 'off the shelf' (Seidel and Abu-Nimer 2015). Therefore, the form they take will differ according to different local contexts, services and needs. We have been talking to various mental health professional groups (such as nurses, Approved Mental Health Professionals and trade unions) and mental health service users/survivors over the past couple of years, generating debate and discussion about the possibility of T&R in the UK. Obviously not everyone would agree to such a process, but we think it could start on a small scale by some willing individuals, grassroots groups and organisations, ideally initiated by user/survivors and their allies, including mental health workers.

In summary, we have made a case for grassroots truth and reconciliation processes to begin the task of peace-building in the context of mental health services, reflecting the concerns of more archetypal T&R commissions at the level of nation states. Moreover, the process may also help expand the horizons of transitional justice, beyond a focus on healing historical abuses, to maximize its transformative potential in new and still-existing settings, like psychiatry. This could extend its reach to include concerns with epistemic violence and injustice, a key feature of psychiatric harm. In accomplishing effective truth-telling, reparation and reconciliation, new forms of dialogic communication and horizontal democracy might emerge that would sustain future alliances *and* prefigure the social relations necessary for more humane mental health services. For example, the sort of dialogue made possible might reveal paradoxical truths which, if accepted and worked with, might result in new and creative ways of working with distress and conflict. As a result, attention might be brought to bear on suicide prevention or crisis intervention, opening up discussions about alternative, less oppressive, forms of support. Ultimately, these processes might be necessary 'to create the world we desperately seek, but which has yet to be realised' (Inwood et al 2016: 63).

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