# Performing restorative justice: facilitator experience of delivery of the Sycamore Tree Programme in a forensic mental health unit

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**Abstract**
Restorative justice has increasingly been used across the criminal justice system. However, there is limited evidence of its use with service users within forensic mental health settings. This study conducted a focused ethnography in a medium secure unit in the UK to explore the implementation of the Sycamore Tree Programme, a specific restorative justice programme that the Prison Fellowship (PF) facilitates in prisons. This article examines the experience of PF volunteers and National Health Service (NHS) staff who came together to run the programme with the first cohort of eight service users ('learners'). Focus groups were carried out before and after training with eight facilitators, and six interviews with facilitators were completed after the programme ended. Furthermore, detailed observations were carried over the six-week programme. It was found that the encounter was highly experiential for staff and that the group process generated significant emotion for both the learners and facilitators. A pre-requisite for containing the group's and the facilitators' emotions was staff taking a relational and collaborative approach to their work. The findings of this study are discussed within the theoretical framework of 'the presentation of self in everyday life' (Goffman, 1959) , looking through the lens of the performative self in social relations.

**Keywords:** restorative justice, sycamore tree programme, ethnography, forensic mental health, self-presentation

## 1 Introduction

Staff working in forensic settings have a pivotal role to play in the recovery of service users who are in their care (Drennan & Alred, 2012; Marshall & Adams, 2018). Staff provide assessments and interventions but crucially have the potential to model and build therapeutic relationships (Aiyegbusi, 2009; Mezey, Kavuma, Turto, Demetriou & Wright, 2010). One intervention that has increasingly been used within the criminal justice system is restorative justice (Braithwaite, 1989, 2018). At its core is the concept of 'reintegrative shaming', which

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enables the wrongdoer to communicate their wrongdoing, take responsibility and make reparation but in a non-stigmatising context (Braithwaite, 1989). Restorative justice initiatives have been associated with lower rates of recidivism relative to traditional justice methods (Hansen & Umbreit, 2018; Sherman & Strang, 2007; Sherman, Strang, Mayo-Wilson, Woods & Ariel, 2015), and victims have reported high levels of satisfaction (Shapland, Robinson & Sorsby, 2011). However, to date, only a limited amount of research has been carried out within forensic mental health settings, in spite of the theoretical and conceptual case for the potential value of restorative practice for a mental health population (Garner & Hafemeister, 2003; Hafemeister, Garner & Bath, 2012; Thomas, Bilger, Wilson & Draine, 2019).

## 1.1 Restorative justice within forensic mental health

Given the prevalence of mental health difficulties among people who have offended, restorative justice initiatives will have taken place with people with mental health difficulties. However, until recently, people with significant mental illness have been excluded from such practices (Drennan, Cook & Kiernan, 2015). Cook, Drennan and Callanan (2015) conducted semi-structured interviews with patients, victims and restorative justice facilitators about their experiences of restorative justice within a secure unit in the UK. Participants across all groups found it to be a positive experience, and patients were motivated to reduce future harmful behaviours and demonstrated improvement in relationships. However, patients reported a sense of vulnerability in facing up to their wrongdoing, and staff reported a sense of vulnerability in relation to stepping outside their customary professional roles. Overall, however, restorative justice was considered to be a positive experience. Van Denderen, Verstegen, de Vogel and Feringa (2020) interviewed 35 social workers about their experiences of victim contact with mentally disordered offenders in 57 cases from four Dutch forensic psychiatric hospitals. They found that there were no mental health conditions or offence types that were automatically excluded from victim-offender contact. However, the timing of the contact, the mental health stability and capacity for insight, and the ability to comply with agreements on the part of the offender patient were all important enabling factors in positive outcomes.

There are a few published case studies that describe the use of restorative justice interventions with women in secure care (Cook, 2019) and a man with autism and mental health difficulties in a high secure hospital in the UK (Tapp, Moore, Stephenson & Cull, 2020). There is also a growing ‘grey’ literature documenting the developments of restorative justice interventions in forensic mental health practice in the United Kingdom and Australia (Drennan & Cooper, 2018).

However, Ward and Langlands (2009) have critiqued the place of restorative justice in the rehabilitation of offenders, pointing out that restorative justice does not have a model of rehabilitation. Typically, offending behaviour programmes employs the incremental and sequential development of skill-based learning in programmes. This allows learning to take place in a step-wise fashion, the steps broken down into a series of skills that accommodate a range of learning styles. Ward and Langlands rightly point out that restorative justice interventions can place an over-reliance on a single, emotionally impactful encounter with a victim to induce behaviour change. While meetings between harmed and harmer are prepared

for, often over months, by restorative justice facilitators, the necessary conceptual understanding and interpersonal skills for a successful restorative justice encounter have not been set out. Suzuki (2020) has highlighted the limited conceptualisation of the notion of 'readiness' within the current understanding of 'why it works' in the restorative justice field. The importance of a clear, structured, needs-adapted preparatory process would be all the more necessary in a mental health population where the effects of illness can give rise to a range of learning needs that impact on rehabilitation interventions (Buckley et al., 2014). It was on the basis of this need for a preparatory, psychoeducational intervention, that the Sycamore Tree Programme (STP) was chosen as a vehicle to introduce the concepts of victim awareness and restorative justice to a forensic mental health in-patient population.

## 1.2 The setting

The STP was delivered at the medium secure forensic mental health unit in London. Medium security is defined as meeting the security requirements of a United Kingdom Category B Prison. All admissions to such units are compulsory detentions under the Mental Health Act (1983, amended 2007) and are usually under the criminal sections of the Act. All admissions will have committed serious or grave offences, and most will have been found to have Diminished Responsibility or, rarely, Not Guilty by Reason of Insanity. Many are transferred from prisons for assessment or compulsory treatment under the Mental Health Act. When found guilty of an offence but with Diminished Responsibility, the courts do not impose a tariff for the offence, but the patient is committed to a secure hospital for treatment. When offences are very serious or repeated, the court can impose an additional section of the MHA, which requires the approval of the secretary of state for justice for discharge. This is a Section 41 and is described under the archaic term of 'without limit of time'; in other words, discharge requires a demonstrable reduction in risk to the public, rather than the passage of time. Discharge requires the approval of a mental health tribunal chaired by a judge or senior counsel, with or without the approval of the responsible clinician, usually a consultant forensic psychiatrist.

The most common diagnosis in forensic mental health settings is paranoid schizophrenia. Schizo-affective disorder (a combination of schizophrenia and a mood disorder) is also common. Personality disorders are frequently coexisting conditions. Traumatic brain injuries and other forms or cognitive impairment are common, and substance use problems are very prevalent. The conditions are typically chronic and remitting/recurring and include the presence of delusional beliefs, hallucinations, disorganised thoughts and speech, impulsive behaviour, impaired social judgment and amotivational syndrome. Poor physical health is very common. The vast majority of patients are treated with anti-psychotic medication, complemented by a range of rehabilitation strategies, including occupational therapy and psychological therapies. Trauma histories in childhood and victimisation in adulthood are very common, as is poor educational and occupational attainment. Treatment occurs on wards of ten to twenty patients, on a pathway from acute admissions to rehabilitation and pre-discharge wards. Ward environments are intended to be therapeutic, with a day programme of structured activity and with a high value placed on relational security between staff and patients, to complement physical and procedural security.

At the start of this project to introduce the STP, restorative justice was almost entirely unheard of in the patient cohorts and not considered relevant by the treating teams, often because it was believed that the evidence base for restorative justice was poor or that the evidence that existed did not apply to the patients under the care of the unit. The latter was most certainly true. In this context there was no call for the introduction of restorative justice or a victim awareness programme. However, there is a constant need for group-based interventions that engage the patients, many of whom lack the motivation to participate in rehabilitation programmes, and that hold promise of greater insight into offending behaviour and the possibility of reduced risk of reoffending. Demonstrable 'victim empathy' is highly prized by mental health tribunal panels when considering possible discharge, although the treating teams tend to value a patient's awareness of their own risk factors, the development of coping skills and compliance with treatment and supervision in the community.

## 1.3 The Sycamore Tree Programme

The STP was developed in the 1970s by Prison Fellowship International (Van Ness, 2007), an international faith-based charity that works with offenders in prison settings, to enhance victim awareness and to prepare offenders for participation in restorative justice if they chose to do so following the programme. The programme has been adapted for implementation in many settings across the world (Fourie & Koen, 2018). The version of the STP that was employed in this study is the accredited programme that runs in prisons in the United Kingdom (Feasey & Williams, 2009; Mullett, 2015). This version of the STP is a group-based intervention run once a week for two and a half hours over the course of six weeks. At the time of this implementation STP was also available in 42 prisons in the UK. When the current study was conducted, the STP had never, to our knowledge, been run in a forensic mental health setting.

The PF delivery team was made up of an experienced tutor and three experienced volunteer facilitators. The PF team were joined by three NHS mental health team members to co-facilitate the programme. Preparation for delivery was through a two-day training course led by the course tutor and the second author, as a senior clinician and the implementation project lead. It was important for the purposes of this implementation and evaluation of the STP that the programme be delivered with a high degree of fidelity to the programme materials as delivered in prison settings. This was to ensure that this STP was comparable to the delivery in non-mental health settings. The only significant adaptation made was to the duration of sessions, which were shortened by 30 minutes, partly to accommodate the routines of the institution and partly in recognition that a session of more than two hours would not normally be attempted with the service users.

In prison settings there are up to twenty 'learners' in each programme. Owing to the vulnerability and high staff support needs of mental health service users, it was agreed that there would be no more than twelve learners on the programme at any one time. The eight participants in the first cohort of the STP delivery were aged between 24 and 52 years. The length of current admission ranged from between 6 and 84 months. The majority of participants were either white British or black British and detained under Section 37/41 of the

Mental-Health Act (1983, as amended 2007) and had a primary diagnosis of paranoid schizophrenia. Index offences were predominantly violent in nature, with the majority of participants having had two or more previous psychiatric admissions and two or more prior convictions.

The materials were delivered partly through large and small group work ('circles'), DVD material, interactive tasks and a bookwork. The programme was highly interactive in its approach. The programme is delivered with a 'tutor', who is the lead facilitator, supported by a certain number of support facilitators who are usually PF volunteers. The 'tutor' facilitates the 'large group' processes, and the support facilitators work with the learners in small groups, structured around the completion of workbook materials. In prison settings, the small group facilitators are assisted by peer mentors. However, owing to the vulnerability of the learners in a mental health setting, this implementation of STP made use of mental health staff to support the delivery as a whole and to specifically assist in the small group work. Sessions 1 and 2 use video material and discussion to prepare the learners for an actual encounter with victim representatives. In session 3, a couple who had been victims of a serious crime came and spoke to the learners about their experience.[1] The victims' story continued to be reflected on in the remaining three sessions of the programme, and the victim representatives were invited back to participate in the sixth and final session. During session 6, the learners prepared an 'act of restitution' (e.g. a painting, a poem, a sculpture) and, rather than the group being formed of only the facilitators and the learners, representatives of 'the community' are invited to be present. Each learner was then invited to stand in front of the audience of peers and community representatives to explain their symbolic act of restitution and what they would take with them from the course. At the end of the session certificates of attendance were handed out by a senior member of the organisation. Finally, a meal was shared by all.

## 1.4 The present study

The aim of this study was to examine the experience of the delivery team implementing the STP within one forensic mental health facility. As this was the first time that delivery of STP was to take place in such a setting, it was important to have the process and experience of the partnership work documented. The outcomes for the learners themselves from the implementation of the programme in a forensic mental health setting will be reported elsewhere. In order to understand the experience of implementation, an ethnographic approach was employed (Hammersley & Atkinson, 1997). An ethnography is a well-established research method that involves 'understanding the experience of a particular group of people, the context in which they live, and the relationship between their experience and the context in which they are embedded' (Harvey, 2015: 390). The ethnographic approach has increasingly been applied to prisons (Drake, 2012; Harvey, 2012; Philipps, 2012) and has also been applied to understanding sex offending treatment in a Canadian prison (Waldram, 2007). Given that this study was concerned with understanding the experience of facilitators of a particular victim awareness and restorative justice programme, a *focused ethnography* was

[1] In this study, Mr Ray and Mrs Vi Donovan came forward to tell the story of how their son died during an assault and their experience of undertaking restorative justice meetings with the three young people convicted of his killing (Donovan & Donovan, 2018; www.chrisdonovantrust.org/restorative-justice).

carried out; here the distinct context of the specified group is explored in detail (Morse, 1987). By taking an ethnographic lens to the process the aim was to unpack the relational and emotional components of the experience.

Given the interactive and performative nature of the STP, this focused ethnography draws on Goffman's (1959) classic anthropological work 'the presentation of self in everyday life' to provide a theoretical framework to the study. For Goffman, interactions with others are performative as though the different 'actors' are on 'stage'. He defines performance as 'all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants' (Goffman, 1959: 26). For example, the role of the lecturer is a performance to students, and the lecturer's sense of self (in that role) is dependent on how she is perceived by others. The lecturer manages their presentation in that role. This 'self-presentation', or 'impression management', is also contained by the 'routines' set out as part of that role. Indeed, the 'pre-established pattern of action which is unfolded during a performance and which may be presented or played through on other occasions may be called a "part" or a "routine"' (ibid.: p. 27). Rossner (2013) has also applied Goffman's (1967) work on rituals to restorative justice conferencing and argues for the need to shift the unit of analysis from the individual to the group and how the sense of self is modified through the interactional process of the restorative justice encounter. Sociologists have expanded on Goffman's work to develop the concept of 'interaction ritual chains' (Collins, 2004) giving rise to collective emotions. A recent case study of restorative justice applied in a forensic mental health setting considered the benefits of the interaction ritual in the positive outcome for both harmed and harmer (Tapp et al., 2020). It will be of interest to explore how the STP delivery team experienced the implementation of this intervention in the novel setting of a forensic mental health unit through a Goffman (1967) 'performative lens'.

## 2 Method

### 2.1 Participants

Focus groups took place, and were audio-recorded, with 8 participants (1 PF tutor, 1 PF trainer, 3 PF facilitators and 3 NHS facilitators) before and after each of the two training days (N = 4 focus groups). Of the NHS facilitators, there were a range of occupational backgrounds, including occupational therapists, nurse managers, a staff nurse and support workers. Additionally, the briefing and debriefing sessions before each session of the programme, facilitated by the lead tutor, were recorded for each of the sessions. Following the completion of the 6 session programme, individual interviews were carried out with 6 participants (1 PF tutor, 1 PF trainer, 2 NHS facilitators and 2 PF facilitators).

### 2.2 Procedure

This study was a short longitudinal focused-ethnographic study. One member of the evaluation team served as ethnographer from the outset. The ethnographer was not employed by the mental health service where the study took place and therefore took the role of the 'outsider', able to observe the process from start to finish. The ethnographer conducted the

focus groups before and after the two training days and observed the interactions of the facilitator during this process. Then, once the group commenced, the ethnographer was present to observe the process of the group being delivered and carried out the focus groups before and after each session. Following the completion of the group, the ethnographer carried out individual interviews. Information and consent forms were provided to the interviewees. The material (the focus groups and interview material) was audio-recorded and transcribed and then subjected to thematic analysis (Braun & Clarke, 2006).

### 2.3 Ethics

This study was approved as a service evaluation by the NHS Trust.

## 3 Findings

Our intention in delivering the STP in a forensic mental health facility was to create a psycho-educational and rehabilitative platform for the introduction of access to restorative justice interventions. We recognised that the skills and concepts needed for participation in restorative justice with victims would need to be gradually introduced to the participants and that through the programme the concepts of restoration, responsibility, recognition of harm, restitution, reconciliation, could be demystified and made accessible. However, through the evaluation data that emerged from the focused ethnography, it became clear that there were other important 'ingredients' in the delivery of the programme that appeared highly relevant to the positive impact on the learner patients. On the basis of the focus group and interview material (and informed by detailed observations), three main themes emerged from the data: 'a relational approach', 'a collaborative approach' and 'an experiential approach'. These themes resonated for the NHS and PF delivery team as part of their experience of the delivery, but were also fundamental and integral to their observations of the impact of the programme on the learners.

### 3.1 A relational approach

From the outset, developing and maintaining a relationship with the learners was evident. The tutor was involved in interviewing the prospective learners before commencing the course. The PF tutor stated that

> I'm a firm believer in [the notion] that people learn from who they know and being relational. I hope to develop warmth and openness in the interview process at referral so that they can connect to the relationship as an experience of learning rather than thinking they need to do this … I will try and make that connection. It doesn't take away the responsibly of the ward and team getting up and taking responsibly but hopefully they will see the value of the relationship – that they connect relationally. (PF Tutor)

Being relational with the learners was seen as central to the process of engagement and change. There was an emphasis on shared humanity and the notion that 'we are all in this process together'. He went on to say:

> Sycamore Tree is about a group, about volunteers giving time, who are ordinary people rubbing shoulders with ordinary people who have made a mistake, the rubbing of shoulders of different people and stories, perspectives, and narratives, and this unlocks the humanness of what's going on. We are all people. Sometimes we label and stigmatise but we are all people. We are all in this together. (PF Tutor)

It was crucial for relationships to be formed not only with the learners, but among the facilitators too. It was recognised that the NHS facilitators had placed trust in the PF facilitators. One facilitator said:

> We had good relationships with them…. They were very happy to allow us to come in as volunteers, people who are completely out of their sphere to work alongside them, with their patients, who they are careful, to allow us to have dialogue with them. (PF Facilitator)

The NHS facilitators were described as 'caring people' by the PF facilitators, and it was appreciated that access was granted to the secure unit. The time spent together on the two-day training, in which the anxiety and the anticipation of the first forensic mental health delivery was shared, enabled trust to be developed among the members of the delivery team. One facilitator said:

> If you do that [spending time], you get a good working relationship, which I think we did, and they trust us and we trust them. We are working on trust here. (PF facilitator)

There was an emphasis on mutual trust among the facilitators who were coming together from different backgrounds. There was an apparent need for facilitators to be able to relate to one another and to feel safe in each other's presence in order for the PF facilitators to then relate more comfortably and confidently to the learners.

## 3.2 A collaborative approach

The importance of the need for the NHS facilitators and PF facilitators to work closely together was recognised. It was also considered essential that the space was contained for staff in order to create a contained space for the patient participants. The facilitators worked well together and were open to learning from one another. This was evident from the training days, where the NHS facilitators and PF facilitators worked well together and respected each other's knowledge base. As one facilitator said (following the training days),

> Today I've learned that working together as a group is more than sum of each of us together and it will bring something new for the service. I am feeling excited. (PF Facilitator).

NHS facilitators brought with them different strengths, and there was a need to respect this. The PF facilitators came into their role with less mental health experience and appreciated the support available from trained mental health professionals. It was apparent that the combination was needed to run the group. One facilitator said,

> I found it comforting cause you can do what you need to do without the level of worry that might be there. You've got someone sitting next to you [NHS facilitator] that has the relationship with the people in group, knows them, understands them, knows that the triggers are, and I don't know what it would have been like without them. (PF Facilitator)

Although the facilitators worked collaboratively, this also brought with it complexity. The language used in the course materials that are designed for a prison context had to be considered and adapted where necessary for a hospital context. For example, it was decided that the term 'learners' rather than 'offenders' would be used. Another consideration in the collaboration was which facilitator should 'take the lead'. One NHS facilitator talked about how they thought that the NHS facilitators should take the lead during the small group exercises. The facilitator said:

> I think the [NHS] group facilitators should be leaders in that group … We know our guys. I was working with the guys from our ward. I work with them day to day so I know how I see them, how I speak to them, treat them, and I know about them. I can use different tools then. [NHS Facilitator]

Furthermore, a PF facilitator expressed a desire for more transparency in the process of collaboration rather than leaving it to emerge organically. A balance was sought. This PF facilitator commented in relation to the small group discussions:

> I thought as a PF person I'd be the one leading the discussion through the questions set and [name of the NHS Facilitator] would chip in. But [name of the NHS Facilitator] found it hard not to say anything, which is fine, so all we did then, was we swapped it around completely. So [name of the NHS Facilitator] asked the questions from the question set and I chipped in with supplementaries. That worked well. (PF Facilitator)

Overall, there was an appreciation of the collaborative approach, and the facilitators recognised and respected the different strengths that were brought. The NHS facilitators were appreciative of the knowledge that the PF facilitators brought, and indeed asked that more time be spent learning from them about the small group exercises prior to delivery. The PF facilitators were also appreciative of the mental health background that the NHS facilitators brought and felt safe that the NHS facilitators knew the background of the learners. It was

through the collaborative and complementary nature of the skill set that the PF and NHS facilitators brought that collaborative working with the learners was enabled. The learners benefitted from the security of working with NHS facilitators known to them and from the novelty of interacting with PF volunteers who enabled novel types of interactions and non-stigmatising acceptance.

## 3.3 An experiential approach

It was apparent from observations and the interview material that what stood out for the NHS facilitators was the experiential and highly interactive nature of the programme. This was a departure from what the NHS staff might have experienced in other group-based interventions. Facilitators and learners were encouraged to be actively involved, and learning was encouraged from observing and reflecting with others. A number of experiential aspects of the programme stood out for the facilitators. These included the 'ripple effect' exercise (session 2), the victim representatives telling their story (session 3) and then the learners presenting their act of restitution (session 6).

The 'ripple effect' exercise stood out for the facilitators and engendered a range of emotions. This session involved the learners being invited to stand around a bucket of water and try to land a coin on a £50 note that was in the water. Then while they were engrossed in this task, an orange was flung into the water by the tutor. Most people got splashed with water as a result. The PF facilitators had completed this exercise before but the NHS facilitators had been given only limited information. There was uncertainty in the room for both the facilitators and the learners. When asked which moment stood out for them the most, one facilitator said:

> Throwing an orange in the bowl of water! I was so shocked at the time. I found it difficult not knowing what was happening and that might be down to my own level of control and usually being in control and running the groups. (NHS Facilitator)

The facilitator went on to say:

> It does take you into yourself because you are dealing with your own emotions, and as a facilitator you need to be out there looking after their emotions. (NHS Facilitator)

This facilitator wanted more certainty, and this lack of certainty was anxiety-provoking. The anxiety also related to how the learners might respond. One facilitator said,

> I feel a little anxious when we do the ripple effect cause of the water. I'm a little more anxious here. It could trigger something and they could kick off. (NHS Facilitator)

However, this experiential approach was also thought to generate a reflective space for the learners. As one facilitator reflected after session 2:

> When you [the tutor] were pushing it about cleaning up the mess they all looked thoughtful. Nobody disengaged. They were all thinking. (PF Facilitator)

It was commented that the learners responded well to this session, and in the small group discussions there was evidence that some learners understood the exercise and thought about the ripple effect on different victims. One facilitator said,

> [name of learner] was taking responsibly. He said he had lots of victims out there who have been effected by what he's done. He's a guy who is putting what he's done in perspective to the rest of society. He's not running away. We are hitting the right note without them either denying it or running away from it. (PF Facilitator)

Another highly significant experiential session took place in session 3, when the victim representatives came to tell their story. This type of dialogue, between patients and victim representatives, had never taken place in the hospital previously. Not only the learners but the facilitators too were immersed in this session; the facilitators also witnessed the victims' story. Some of the NHS facilitators said that witnessing the victims' story as part of an intervention was quite a shift for them because they might not have been in a position before where they might have shown an intense emotional response in front of service users. Reflecting back on this session, one facilitator said:

> I was nervous about that session. I knew the story was going to be distressing, but I didn't know their story, and so I was kind of worried about, or conflicted I guess in my head on do I show genuine emotion and how does that make me look as a member of staff? Or do I hold it together, and if I hold it together do I notice what's happening for the patients? (NHS Facilitator)

This comment led to a fruitful discussion among the facilitators about what it might mean to show some vulnerability in front of service users.
Session 3 was seen as significant to the programme for the learners. When asked to reflect on how the tutor thought the session went, he said:

> Always is the pivotal session. I think it felt a very emotional session, very deep work going on for guys where they are starting to process that this couple have lost their son and they've met the guys who killed their son and they're here talking to us. It's a lot to process. Some of the guys got emotional, a few were slightly tearful and they were also very respectful and in their own way they were very touched. When you hear a story like that for the first time it can really touch you. (PF tutor)

Following session 3, the facilitators appeared more relaxed and reflected on how well they thought the session had gone. One NHS facilitator said:

> We've offered something to the guys that we've never offered before and they really took the bull by the horns and ran with it. It was amazing. A real relief and lighter. I

> was worried about hearing it and my reaction with the guys. It was the fear of the unknown. (NHS Facilitator)

There was a perception that the learners were ‘more vulnerable’ and ‘more emotional’ than usual. It was commented with regard to one of the learners, who had a tendency to fall asleep during the sessions, that the person had been ‘awake the whole time’. Session 3 was seen as a ‘turning point’ for the learners. One facilitator said:

> I felt last session, it felt grounded, calm and contained and for every guy in the room the hook has gone in. And even, for example, one might not come back today, if he leaves he will leave with a hook in him. So we ask the question, does six sessions work? It might be for this one guy one session has nudged him into a place that he might not have been before. (NHS Facilitator)

Session 6, another experiential session, which involved the active participation of the learners, in a public space, was also reflected on by the facilitators. There was surprise among the NHS facilitators that most learners attended this session as it was commonly thought that the intensity of the exposure of being invited to stand and explain the ‘act of restitution’ would be too much for the participants. However, the effort and thought that most learners put into their ‘act of restitution’ was deeply moving for the staff participants, and it appeared to be so for the learners too. There were poems, songs, paintings, drawings and constructions, but what was most important was the emotional depth of the explanatory narrative that accompanied the creative output. Much of this emotional outpouring was directed respectfully and gratefully towards the two victim representatives who attended the session to ‘witness’ the ‘act of restitution’. Some of the facilitators described an emotional reaction to the session too. One said,

> I hadn’t even got a tissue. I wasn’t expecting it to be quite so moving. I thought a lot of them would have avoided it and I was surprised by their level of openness. They normally wander round putting on the ‘tough guy’. (NHS facilitator)

The experiential nature of the group therefore generated emotional responses for the facilitators, and they thought it generated emotional responses from the learners too. This work was seen as different from other rehabilitation groups and required the facilitators to also move outside of their ‘comfort zone’ to being emotionally authentic in their responses. This session appeared to be another example of an ‘interaction ritual chain’ that powerfully generated ‘collective emotions’ across the social distance of the staff/patient divide. Much of the growth-promoting power of the group was felt to lie in the degree to which it was experiential for the facilitators and learners in tandem.

# 4 Discussion

## 4.1 Restorative justice as a performative act

Drawing on the observations and interview material in this focused-ethnography, the STP can essentially be seen as a performative act with a number of 'actors'. It took *an experiential approach* to fostering recovery and can be seen as an example of the 'creative programming' necessary to encourage recovery processes (Anthony, 1993; Drennan, 2018; Drennan & Alred, 2012). From the perspective of the facilitators, while the PF tutor and PF facilitators have 'performed' this programme before in prison, the NHS facilitators were 'performing' this for the first time. The stage was more experiential than usual, creating a space for a new dialogue and a different interactional style with the learners. Goffman (1959) talks about how 'actors' might, at times, intentionally disrupt the appearance they are trying to create, by acting in a manner that creates dissonance between how the audience might think we ought to present versus how we are actually presenting. Goffman would describe this as 'scene' (as in a play) and states that the common sense phrase 'creating a scene' is apt, because a new scene is created with these disruptions (ibid.: p. 205). Within the STP new 'scenes' were created. For example, just as the learners were looking closely into a bowl of water, an orange was flung it, causing them to be splashed. Observing this moment, it was obvious that there was a disruption in social interaction between how a facilitator might usually behave (or 'act') in front of a service user. We would again argue that this increased the opportunity for learners to experience something new and shift how they might 'perform' their own journey of recovery.

Furthermore, we found that this approach, through the process of experiential learning (through the different 'rituals'; e.g. the act of restitution) enabled the visceral expression of emotion. Goffman's (1959) ideas in relation to the 'back stage' and 'front stage' are helpful here. He differentiates between the 'social' role that we present to others on the 'front stage', which includes our appearance, our manner of interacting, our pattern of speech, and our body posture, and from the 'back stage', where the self-presentation 'mask' is removed and the self behind the mask is revealed. During the STP the usual 'front stage' for the NHS facilitators was challenged. It was found that the experiential nature of the programme revealed emotions that the facilitators had to manage in front of other facilitators and learners. As one facilitator said, '… do I <u>show</u> genuine emotion?' and 'how does that make me <u>look</u> as a member of staff … ?' While not showing emotion might have been the usual presentation of self for the staff, now they were in a position in which not showing emotion (when hearing the story of the victims) would have been counter-conducive to modelling empathy. This resonates with other authors who have noted that the delivery of restorative justice interventions for patient infractions in mental health settings requires the staff who participate to tolerate a greater degree of emotional vulnerability than they typically would in their professional roles (Cook et al., 2015).

At the heart of the programme was the need for staff to be aware of their own emotions while simultaneously holding in mind the emotions of the learners. Keet (2010) has described how authenticity and intrinsic motivation in volunteer participants is a key factor in the success of many community-based restorative justice programmes. Rossner (2013), in her examination of the microstructure of interactions within restorative justice conferencing in the community,

found that emotions played a central role. She noted that the transformative ritual of the restorative justice encounter gives rise to emotional energy, which, in turn, allows for feelings of solidarity and a shared sense of morality to develop. However, she points out that emotions need to be carefully managed in order to impact successfully on a conference. The emotional expression of learners within a small group was observed to be intense and deserving of careful consideration. Indeed, a delicate balance has to be reached within this process in order to ensure that meaningful work can occur in a contained manner. Therefore, given that emotional energy is argued to allow for the potential of transformation for learners, it is important to ensure that the facilitators, while experiencing their own emotional reactions, are able to hold and contain the emotions expressed by the learners too (Drennan, 2018). This is a complex psychological process, requiring the facilitators to mentalise (Bateman & Fonagy, 2016). This study found that to enable the facilitators to manage this dynamic and complex process they needed to firmly establish both a *relational* and a *collaborative* approach to the work. The development of trust between the facilitators was a prerequisite for management by the facilitators of the performative aspects of their role while engaging in the 'rituals' inherent within the structure of the programme.

## 4.2 Limitations of the study

Firstly, the study is based on running the first cohort of the programme and with a small number of facilitators. Moreover, the study took place in one unit. Caution is therefore called for in generalising to other secure settings. It is important, however, to emphasise that the NHS facilitators did come from a broad range of occupations. Second, the NHS facilitators who took part were self-selecting, and therefore their motivation could have been a key factor in driving how well the programme ran. However, it could be argued that motivation is indeed a prerequisite for staff being facilitators in the first place. Finally, it is notable that the PF tutor particularly prized being relational and the need to highlight our shared common humanity. Thus, a potential 'tutor effect' would need to be borne in mind. The emotional impact of the victim testimony in session 3 is another important component of the STP but one that will have a differential impact depending on the communication style and emotional congruence of the victim representatives. Victim representatives who are overly 'professionalised' through frequent participation in the STP can reduce the experience of authenticity (Anderson, 2018). The victim representatives in this delivery of STP have participated in prison settings on many occasions, but the emotional impact of their account was not undermined. However, this may not always be the case, and the victim testimony remains a significant variable in the delivery of the STP.

## 4.3 Implications for practice and research

The findings of this study highlight the importance of careful preparation in the delivery of a 'high challenge/high support' programme (see the social discipline window (Wachtel, 2005)). Intrinsic to this preparation is the support of the host organisation. The PF tutor had the opportunity to understand the context of the environment and had met many of the learners before they participated. Moreover, the facilitators had the opportunity to spend time with one

another before running the group. Relationships mattered. Second, it would be of interest to extend the programme to women and evaluate its effectiveness. Finally, the STP, when facilitated in prisons, includes peer mentors (who have previously completed the programme). It would be of interest to include peer mentors in future programme delivery and to evaluate their role. However, forensic mental health settings would need to invest in developing an infrastructure in which this is possible, while managing a range of governance issues (confidentiality, preparation and aftercare for peer mentors). This would be a significant addition to the task of programme delivery in a mental health setting.

## 5 Conclusion

This study is the first of its kind to evaluate the experience of staff facilitating a victim awareness and restorative justice group programme with participants who have significant mental health difficulties and who are detained in a secure hospital. Ultimately, this emerged as an experiential performance that required the facilitators to reflect not only on the emotions of the learners, but also on the extent to which they revealed their own emotions on the 'front stage'. Indeed, the curtain was drawn back, and the 'back stage' was more prominent, allowing for a greater sense of common humanity and solidarity to prevail. Moreover, as Cook et al. (2015) found, it was necessary for the facilitators to be skilled at having a containing role with a complex and vulnerable group. While power imbalances continue to be at play in the interaction between staff and the learners, and while clear boundaries needed to remain in place, the exposure of emotion 'in the room' allowed for the group to move beyond a more superficial 'script' to a meaningful human encounter. Including peer mentors in the future (albeit with careful consideration) could perhaps bring about a further microculture shift between 'staff' and 'service users' and allow for further co-production and collaboration in relation to recovery.

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