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ANDREA COOK BSc Hons

THE USE OF RESTORATIVE APPROACHES IN A FORENSIC MENTAL HEALTH  
SETTING

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A thesis submitted in partial fulfilment of the requirements of  
Canterbury Christ Church University for the degree of  
Doctor of Clinical Psychology

OCTOBER 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY



**CANTERBURY CHRIST CHURCH UNIVERSITY**  
**Doctorate in Clinical Psychology (D.Clin.Psychol.)**

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## **Summary of MRP Portfolio**

### **Section A**

This paper examines the research literature exploring the place of shame and/or guilt as psychological mechanisms leading to change in restorative justice interventions. Nine relevant papers are reviewed. There was some evidence of shame being a key emotion experienced in RJ interventions and some links were found between the nature/management of such shame and outcomes. This was not consistent and some studies found no significant results. From the studies reviewed it is not yet possible to reach a coherent theory of the underlying processes of RJ although there are some indications as to the way forward. It is concluded that perhaps the key area for investigation is the detail of the process including how shame is both experienced and managed.

### **Section B**

This paper reports a grounded theory investigation into the implementation of restorative approaches in a forensic mental health setting. A model is developed depicting the interplay of psychological and organisational factors associated with the use of restorative justice in this setting. Results indicated that staff members and patients found the intervention to be meaningful and useful when used to address incidents occurring on the wards. Restorative approaches are found to be congruent with models of mental health and offender recovery. Processing emotions, developing thinking and coherent narrative, and immediacy are found to be key components of the intervention. The research findings are discussed in relation to existing theory and research. Further research is recommended to build upon these early findings.

### **Section C**

This paper provides a critical appraisal of the research process through the consideration of four questions: 1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further? 2. If you were able to do this project again, what would you do differently and why? 3. Clinically, as a consequence of doing this study, would you do anything differently and why? and 4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

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ANDY COOK BSc Hons

Section A:

What evidence is there for shame and/or guilt being component psychological processes underlying restorative justice interventions?

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**What evidence is there for shame and/or guilt being component psychological processes underlying restorative justice interventions?**

---

**Abstract**

This paper provides a critical review of the research literature exploring the place of shame and/or guilt as psychological mechanisms leading to change in restorative justice interventions. Restorative justice is described in terms of its origins and current expanding role in the criminal justice field. The suggested outcomes of restorative justice are considered in relation to rehabilitation and recovery processes. The psychological theories that have become associated with restorative justice are presented with a focus on the role of shame and the concept of reintegrative shaming. A literature search was carried out on five electronic databases in order to identify research on the psychological process of reintegrative shaming and restorative interventions. Nine relevant studies were identified and are critically reviewed. The majority of the studies are quantitative and rely upon pre and post intervention measures of shame or related affect. There is some evidence of the process of reintegrative shaming and associated positive outcomes, but findings were not consistent across studies with some finding no significant results. Complexities in operationalizing and measuring reintegrative shaming are discussed. The one qualitative study did not find evidence of reintegrative shaming and provided an analysis of how restorative justice interventions may become a formulaic exercise rather than truly restorative. Clinical implications are considered and recommendations are made regarding further research.

## **Introduction**

In England restorative justice (RJ) schemes have been increasingly implemented and the process has become the focus of media attention (see for example, BBC One, 2012; Fuhl, 2012; BBC News, 2011). The aspiration of working towards healing for all those affected by a crime is particularly pertinent at a time when victim satisfaction in some police forces is low (BBC News, 2013) and the Government recognises that victims do not feel that their views are taken into account by a “bureaucratic” and “confusing” criminal justice system (Ministry of Justice, 2012). In contrast, evidence from a number of studies indicates that RJ is popular with victims (Liebmann, 2007) and RJ is rapidly gaining recognition as a mainstream criminological practice (Gavrielides, 2007; Hughes & Mossman, 2001).

The intention of this paper is to consider the research examining the psychological processes of offenders which are associated with RJ interventions. If RJ has positive outcomes for both the offender and victim in a number of domains then it is of clinical significance to understand the mechanism of these changes.

## **Origins, Use and Definition of Restorative Justice**

RJ aims at best to address the harm done to all primary individuals affected by a specific offence. RJ is usually defined as a process with a focus on repairing harm rather than inflicting punishment (McCold, 2004; Zehr, 1990). Marshall (1999) defines RJ as:

“... a process whereby all parties with a stake in a particular offence come together to resolve collectively how to deal with the aftermath of the offence and its implications for the future.” (p.5)

Others have criticised this definition as having little to say about the values or end result of the RJ process (Braithwaite & Strang, 2001; Walgrave, 2007; Zernova & Wright, 2007). A richer view of RJ encompasses the possible transformative nature of a restorative encounter

between stakeholders and also the principles of voluntary participation, repairing harm and building peace. These principles have evolved from practice in the use of mediation between victims and offenders originally in America (Barnett, 1977), but also strongly influenced by community justice practiced in non-Western cultures such as Native American and Maori (Diamond, 2012). The latter influences have had a particular impact in widening the practice from a narrow offender/victim focus to a wider family and community focus.

The practice of RJ can involve different processes, including face-to-face meetings between offenders and victims, conferencing in which victim and offender are supported by their communities, and intermediated contact between victim and offender (Walgrove, 2005). Llewellyn & Howse (1998) state that the main components to the restorative process include truth-telling, voluntary participation and a face-to-face encounter. Other practices allow the repair to occur without the necessity of a face-to-face meeting (Sherman & Strang, 2007). A range of actions may be agreed as a result of the process: including restitution, compensation, reparation, reconciliation and apologies (Walgrove, 2005).

In England the Government plans to develop and deliver RJ interventions at each stage of the justice system (Ministry of Justice, 2011). The development of RJ schemes has initially been sporadic and dependent upon funding which has often been time limited (JUSTICE, 1998). The majority of early schemes targeted juvenile offenders who had committed relatively minor offences. RJ schemes aimed at adult offenders and more serious offences have increased gradually and in 2001 the Home Office provided funding to a number of schemes under its Crime Reduction Programme (Shapland, Robinson, & Sorsby, 2011).

The variety of modes of delivery of RJ programs, and the pursuit of multiple objectives by such programs, poses some complications for research and evaluation tasks. Presser and Van Voorhis (2002) suggest that RJ interventions are a response to crime or



boundary transgression aimed at repairing harm, and are defined by the presence of three core processes: dialogue, relationship building and communication of moral values. This definition of RJ interventions will be used in this paper.

### **Outcomes Associated with Restorative Justice**

A growing body of research indicates that RJ approaches reduce recidivism, increase restitution compliance, have a positive impact upon post-traumatic stress symptoms among victims and provide both victims and offenders with more satisfaction than more traditional judicial methods (Barton, 2003; Latimer, Dowden, & Muise, 2005; Sherman & Strang, 2007). The evidence base continues to increase with studies focussing on a range of offence types and offenders (Bazemore & Maruna, 2009).

Latimer, Dowden and Muise (2005) conducted a meta-analysis including 22 unique studies and concluded that RJ was more successful than nonrestorative approaches in reducing recidivism, increasing offender compliance with restitution and giving both offender and victim satisfaction. They identified limitations in the generalisability of results due to a self-selection bias in the studies as RJ is a voluntary process. This bias could account for the positive outcomes, as it is arguable that willingness to engage was indicative of a readiness to change (Prochaska & DiClemente, 1983). The authors also reported a lack of data on facilitator training, offender history and the relationship between the offender and victim, all of which could be confounding variable. The majority of the studies related to youth offenders (74.3%) which limits generalisability of results. Sherman and Strang (2007) systematically reviewed the evidence on RJ examining “what works for whom” and concluded that RJ best reduces offending and helps the victim when there is a personal victim and when the crime is either violent or burglary. The cohorts consisted of both adult and youth offenders. Studies were only included if RJ effects were compared with other criminal

justice interventions for similar cases, or predicted re-offending rates based upon a validated scale. This latter inclusion could introduce bias to the results given the self-selection bias of restorative interventions; as stated above the choice to take part in a restorative intervention could be indicative of readiness to make lifestyle changes. Whilst these studies offer some theory regarding the psychological mechanisms that lead to the effects, the mechanisms of change are not the focus of the research.

### **Theories Associated with Restorative Justice**

RJ interventions originate from practice rather than theory: theory has been applied in an attempt to understand the process. Ledwidge (2012) postulates an evolutionary explanation for both the restorative and punitive approaches to justice, based upon the necessity for different in-group and out-group reactions to transgressions in order to retain tribal integrity and survival. A restoratory approach would avoid outcasting a member of the community and also work towards future safety from further transgressions for the community. There has been an emphasis upon punitive reactions to crime in current western society but it is increasingly recognised that at best the effect of such deterrence is limited, and the infliction of punishment can bring with it shame and stigma for the offender, both of which can impact adversely on rehabilitation (Wright, 1996). Zehr (1990) discusses the ethical basis of restorative interventions with reference to Christian biblical values, and argues for a paradigm shift away from punitive interventions.

Although RJ is not framed as a therapeutic intervention, some of the processes and outcomes of restorative interventions appear to have parallels with those of therapeutic interventions. For example, RJ has components in common with the Good Lives Model which is a holistic approach to rehabilitation (Siegert, Ward, Levack, & McPherson, 2007) in that the practice of RJ aims to be beneficial to both victims and offenders through a process

of redress, healing, recompense and fair treatment (Van Ness & Strong, 1997). This journey away from stigma and shame towards rehabilitation and healing also has clear parallels with the recovery model in mental health practice (Repper & Perkins, 2003). The potential for relationship building as well as making amends within restorative approaches (Bazemore & Maruna, 2009) has clear links with secure recovery approaches (Drennan & Alred, 2012). Barker (2012) suggests that offender recovery should include the goal of supporting the offender to understand their harmful behaviour and how their life experiences and choices have contributed to this and RJ appears to provide a route to facilitate this. Ward and Langlands (2009) suggest that RJ and rehabilitation interventions are complementary and overlapping, but advise against blending the two processes. They argue that whilst some therapeutic needs might be met by a RJ intervention, this is a by-product of the intervention rather than the main aim.

It has been noted that restorative conferences are usually experienced as emotive by those attending (Moore & McDonald, 1995). Affect theory, and in particular Nathanson's (1992) compass of shame has been applied to the RJ process. Shame has been considered a key emotion in making sense of offender behaviour and it is commonly agreed that by-passed shame can promote anger (see for example Gilligan, 1997). Defining and measuring experiences of shame, guilt, embarrassment, exposure and pride in relation to offending behaviour has been the focus of academic attention in relation to rehabilitation. It is pertinent to give an overview of some of the issues raised which are relevant to the restorative process. Shame has been defined as arising from awareness of others' disapproval whereas guilt has been defined as arising from transgressing internalised beliefs and values (Gibbons, 1990). Alternately, shame has been described as a negative evaluation of self whereas guilt has been defined as a negative evaluation of a specific behaviour (Lewis, 1971). Using the latter definitions, Tangney, Stuewig, Mashek, and Hastings (2011) found proneness to guilt to be

adaptive whereas shame-prone offenders were more likely to have psychological symptoms and substance misuse problems. Additionally, guilt-proneness was found to be a protective factor with regards to recidivism. This would suggest that it is guilt that needs to be induced in restorative processes rather than shame. However, other research has not found differences between shame and guilt but rather identified a shame-guilt factor which was associated with remorse (Harris, 2001). Harris, Walgrave, and Braithwaite (2004) question the differentiating of shame and guilt on theoretical dimensions, and suggest it is not possible to have internalised values which are divorced from life context and the opinions of others. Braithwaite and Braithwaite (2001) suggest that in the case of serious wrong-doing it is not enough to feel guilt about the act but some shame about personal identity is also necessary in order to lead to a transformative process, as long as such shame does not encompass a total rejection of self. The experience of shame about self has links with the rebiographising and reverting to an unspoiled identity described by Maruna (2001). Maruna found that those long-term offenders who desisted from further crime had been able to evolve an identity which they believed had always been present but that had not been to the fore due to circumstances surrounding their offending.

Braithwaite (1989) distinguishes between two types of shaming practices, naming them “reintegrative shaming” and “stigmatising shaming”. Braithwaite’s theory of reintegrative shaming has become the central theoretical basis for understanding restorative interventions. This theory proposes that reintegrative shaming acknowledges and discharges the shame, thus facilitating a reconnection with community, whereas stigmatising shaming leads to the creation of an outcast group and the likelihood of further crime. The absence of stigmatisation and the opportunity to both feel and resolve shame have been identified as key in the process of rehabilitation (Ahmed, Harris, Braithwaite, & Braithwaite, 2001). Whilst some have named this emotion guilt (Tangney, Stuewig, Mashek, & Hastings, 2011) and

others remorse (Maxwell & Morris, 1999), there is some agreement that these emotions result from recognition of wrongdoing and if harnessed productively can lead to the desire to make amends. Social identity theory suggests that the recognition of wrongdoing would need to be in relation to the values of those we trust for social validation in order to have an impact upon identity (Tajfel & Turner, 1979). RJ practices recognise this in the use of ‘supporters’ from the offender’s social or family network in the shaming process (Restorative Justice Council, 2012). It has been suggested that the process of reintegrative shaming highlights dissonance between social identities of the offender and creates an opportunity to either reject or accept the ethical norm in order to resolve the internal conflict (Harris, 2001).

### **Rational for this Review**

There is evidence that RJ is being widely adopted within mainstream criminal justice practices. There are claims that it produces beneficial results for victims, offenders and the community across a number of domains. If restorative approaches are to be delivered effectively it is important to gain a psychological understanding of the process and the key mechanisms of change. In order to do this the proposed theoretical understanding of the restorative process and the impact that this has upon personal functioning needs to be investigated in practice.

### **Search Strategy**

The databases PsycINFO, ASSIA, Web of Science, Social Policy and Practice, and Cochrane Database of Systematic Reviews were searched using the search terms “restorative justice” AND “shame OR guilt OR therapeutic change OR therapeutic process OR psychotherapeutic process OR psychotherapeutic techniques OR psychological process”. Searches were limited to 1986 to 2013 as the term “restorative justice” was not used prior to

1986. Papers were limited to peer reviewed journals in English language. The results of the search presented 67 separate papers; the details of which are shown in Appendix 1.

Abstracts were searched manually for studies examining the process of RJ approaches for the offender. This included studies which aimed to investigate the differential impact of reintegrative shaming and stigmatising shaming, and also studies which proposed to investigate the process of a RJ intervention as defined by Presser & Van Voorhis (2002).

Studies related to the use of shaming in parenting were excluded on the basis of the confounding variables this would introduce due to the breadth of family culture and functioning. Studies requiring participants to reflect on hypothetical situations were excluded on the basis of ecological validity.

Nine studies were identified which met these criteria and all nine are discussed. Outlines of the nine studies are shown in Table 1. An assessment rating of each study is given based upon quality assessment tools (Critical Appraisal Skills Programme, 2010) in order to give a sense of the quality of each paper. Further detail of the ratings is given in Appendix 2. One study stands out as having methodological problems (Roseman, Ritchie & Laux, 2009) but it remains heuristically valuable, with further statistical investigation required.

Table 1

Summary of studies

study	location	participants	intervention	methodology and measures	rating
Makkai & Braithwaite 1994	Australia	Staff of 410 nursing homes Reduced to 341 nursing homes at T2	Inspection of compliance with standards by inspection teams with different approaches	Difference in compliance with standards between first inspection and second inspection 18-24 months later	14/16

Harris 2003	Australia	720 people apprehended for driving while over the legal alcohol limit ( 24% female, 76%% male, mean age 30 years)	Randomly assigned to court or RJ conference	Interview 2-4 weeks after intervention 5 point self-report scales of shame, guilt, embarrassment, empathy and anger/hostility	12/16
Harris 2006	As above	As above	As above	As above Scales of reintegration and stigmatisation developed	13/16
Tyler et al. 2007	As above	As above	As above	As above plus further interview at 2 years post intervention and analysis of police records 4 years pre and post intervention	13/16
Murphy & Harris 2007	Australia	652 people who had been caught and punished for investing in illegal tax schemes (aged 25-76, 83% male, 17% female)		Survey of 200+ questions Scales of reintegration/stigmatisation developed Measure of shame acknowledgement /shame displacement developed Tax non-compliance scale developed	13/16
Roseman, Ritchie & Laux 2009	America	13 men on parole or probation following conviction for a sexual offence (all white, mean age 40)	Sex offender treatment programme Assigned to 1 of 3 groups each with a different level of exposure to victim testimony	Pre and post intervention measures Balanced emotional empathy scale (BEES) Personal feelings questionnaire-2 (PFQ-2)	10/16
Jackson 2009	America	69 adult offenders attending a court ordered victim impact training program (various offences, 47 male, 22 female, 63 white, 6 minority, aged 18-66)		Pre and post intervention measures Test of self-conscious affect for socially deviant Mehrabian emotional empathy scale	14/16

Loeffler, Prelog, Pabba Unnithan & Pogrebin 2010	America	115 men convicted of domestic violence offences (control group mean age 37, restorative group mean age 30)	Domestic violence treatment programme in 6 locations Control groups of CBT and restorative groups	Pre and post intervention measures Rosenberg self-esteem scale Levenson multidimensional locus of control scale Interpersonal reactivity index scale	15/16
Kenney & Clairmont 2009	Canada	Participants of 28 youth RJ conferences: 37 young offenders (30 male, 7 female), 34 victims and supporters of offenders and victims	RJ program offered as an alternative to court for young offenders	Observation of restorative conferences Field notes transcribed, coded and categorised	14/16

## Studies

The majority of the studies identified are quantitative. Some solely investigated the emotional processes occurring within restorative or mainstream responses to crime. Others went a further step and examined whether there was a relationship between the processes identified and outcomes such as reduced recidivism. A challenge for these studies was the operationalisation and measurement of the key concepts of reintegrative shaming or stigmatising shaming. This was not approached in a standardised manner; some researchers developed measures whilst others used a variety of pre-existing tools. Researchers largely relied upon self-report to determine the emotions experienced thus posing validity problems due to the possibility of misreporting and the subjective nature of answers (Mosher, Miethe, & Phillips, 2002). The measures and outcomes of the quantitative studies will be discussed first before returning to the methodological challenges faced. The one qualitative paper will then be considered before drawing conclusions from all studies reviewed.

**Measures and Outcomes in Quantitative Studies Reviewed.** Harris (2003; 2006) used questions based upon conceptualisations of shame, guilt, embarrassment, empathy and



anger/hostility which participants answered with 5 point self-report scales. A factor analytic approach identified a single shame-guilt factor, with further factors of embarrassment-exposure and unresolved shame. Unresolved shame was positively correlated with anger/hostility which was viewed as supportive of the theory of stigmatising shame. Roseman, Ritchie and Laux (2009) used a self-report questionnaire to measure empathy levels and shame and guilt levels pre and post interventions which were deemed to induce varying levels of shame or guilt. Results of t tests showed no significant differences between groups in the changes of empathy, guilt or shame following the different restorative interventions. Possible reasons for the lack of significant results include many methodological limitations of the study which are explored later.

Loeffler, Prelog, Praba Unnithan and Pogrebin (2010) used well established measures and found significant treatment effects for self-esteem and empathic concern following a restorative intervention as compared to a control group. The authors viewed this to be evidence of successful shame transformation. Conversely, Jackson (2009) found no significant differences between offenders' responses on their development of guilt, shame, and empathy over time on either a 4 week or 10 week restorative program. The authors differentiated between guilt and shame and found that shame-prone individuals were less likely to be empathic. They did not use the term stigmatising shaming but did postulate from the results that reintegrative shaming and constructive guilt are similar constructs.

Makkai and Braithwaite (1994) took a different approach in that they investigated interventions which had not deliberately been set up as restorative. They used answers from questionnaires to categorise the methods of inspection teams as reintegrative or stigmatising, and then examined the performance of nursing homes in relation to the type of inspection received. The criteria they used to determine a reintegrative shaming ideology was based upon both a willingness to express disapproval coupled with a desire to "forgive" and move

on. They found that significantly improved compliance followed an inspection by a team with a reintegrative shaming ideology and that there was a stronger effect when inspectors were known to the directors of nursing. This latter point supports the practice of using supporters in restorative conferences. Similarly, Murphy and Harris (2007) investigated an intervention that was not framed as RJ. They took a different approach in that they explored the perceived experience of the intervention rather than investigating the ideology of those imposing sanctions. Results indicated that those who who experienced the intervention as more integrative and less stigmatising reported less recidivism in the subsequent years. This was regarded as support of the reintegrative shaming model although causality could not be determined. Shame displacement such as anger towards the system predicted future non-compliance but shame acknowledgement was unexpectedly negatively associated with reintegration.

These studies illustrate the problems associated with conceptualising reintegrative shaming and empirically measuring the component or associated emotions. The results are mixed. There is some evidence that stigmatising or unresolved shame is linked with a negative emotional outcome of anger and hostility. There is also some evidence that reintegrative shaming leads to a positive emotional outcome of increased empathy and/or compliance with societal boundaries. However, these results are not consistent across the studies and some studies found no significant effect. There are vast differences between the studies in terms of the crimes/transgressions examined, the restorative process used and the measurement of processes and outcomes.

**Methodological Factors in Quantitative Studies Reviewed.** Two of the studies (Harris, 2003; 2006 ) used the same data set relating to 720 drink drivers who were randomly assigned to either attend a court intervention or a restorative conference. The surprising aspect of the first study was the similar findings in the two conditions, the consequential

decision to analyse the results together and the lack of discussion regarding this. This was revisited in the second study in which scales measuring reintegration and stigmatisation were developed. Participants who attended restorative conferences perceived the experience as more reintegrative but there was no difference in how stigmatising participants experienced the two interventions. Whilst the statistical analysis is detailed clearly and the large sample sizes give statistical power, the findings are based upon measures that have not been validated. The studies relate to a crime without a victim and it would be unwise to generalise the findings regarding shame to situations in which harm has been caused to an individual.

A third study (Tyler, Sherman, Strang, Barnes, & Woods, 2007) was the only longitudinal study identified. Researchers used further data from the same drink-driving experiment and examined the relationship between the different intervention experiences and outcome data. It was found that RJ conferencing did not have a significant impact on recidivism compared to traditional court processing at the 2-year follow up, based upon self-report and examination of police records. A significant treatment effect was found in that offenders assigned to restorative conferencing indicated that they made a greater effort not to drink and drive than those who were assigned to court processing. There was also a significant difference in that offenders assigned to diversionary conferencing indicated a greater belief in the legitimacy of the law compared with offenders who went through court processing. The authors consider a number of possible explanations for the findings and conclude that the results support the reintegrative shaming models of restorative treatment but that in this case the effects of the treatment were too weak to impact upon recidivism rates. Weakness of treatment effects in this study could be due to the quality of implementation of the conference or could be due to the absence of a personal victim to activate stronger psychological responses. Alternately, this study could be viewed as demonstrating that court

processes and restorative processes can be equally effective in addressing recidivism of drink driving.

Roseman, Ritchie and Laux (2009) studied the impact of guilt and shame on empathy development with sex offenders in a treatment program. Thirteen participants were divided into three groups and each group received a different level of exposure to the testimony of a victim of sexual abuse: reading a letter from the victim, seeing a videotape of the victim, or live interaction with the victim. Self-report questionnaires were used to measure empathy levels and shame and guilt levels pre and post intervention. Information regarding the reliability and validity of the scales used was not presented. Results of t tests showed no significant differences between groups in the changes of empathy, guilt or shame following the restorative interventions. The study was limited by the small number of participants which may have been inappropriate for parametric statistical analysis. There is no analysis which takes into account all three levels of exposure. Additionally there was not random assignment of participants to groups and groups were in different settings which may have brought uncontrolled factors into the process. The lack of significant results could be due to methodological limitations, the way in which the intervention was delivered, or because restorative interventions are not effective with this population.

A similar study examined the impact of restorative approaches within a treatment program for domestic violence offenders (Loeffler, Prelog, Praba Unnithan, & Pogrebin, 2010). In this case the victim perspective was introduced via role play and psychodrama whereas the control group received standard cognitive behavioural treatment. This study benefitted from a good sample size, giving power to the analysis. The researchers used well established measures but again did not randomly allocate participants to groups. Follow up studies would be useful in determining how the significant treatment effects of increased empathy were translated into future actions and psychological functioning. Jackson (2009)

also examined a group treatment program, in this case for a heterogeneous group of offenders, which included dialogue with a victim of crime. A strength of this study was the examination of a variety of potentially confounding variables. The results indicated that gender moderates development of guilt and empathy. It is not clear whether the victim experience matched the crimes committed or whether the authors viewed this as a relevant factor.

There were two studies which examined interventions which had not been designed as restorative. Makkai and Braithwaite (1994) examined the compliance of nursing homes with standards and Murphy and Harris (2007) examined the behaviour of tax evaders following government enforcement initiatives. In both cases the interventions were divided into reintegrative or stigmatising, based in one case upon the delivery of the intervention and in the other on the experience of the intervention. Considering these different approaches raises the question as to whether the intended delivery of an intervention as reintegrative or stigmatising matches the experience, or whether this is mediated by other factors. It is not clear how the intervention was delivered in Murphy and Harris's (2007) study; whether it was face-to-face or conducted by other means and what factors led to the differential experiences of the intervention. These are key omissions in understanding the process of reintegrative shaming and also considering the generalisability of the results. Makkai and Braithwaite's (1994) study provides much richer information regarding the process of the intervention and the relationship between this and outcomes. The focus of the latter research in which there was no crime, no victim, and responsibility for upkeep of standards was presumably dependant upon a team approach is very different from the case of an individual criminal, which raises questions about generalisability of results.

**Review of Qualitative Study.** Only one qualitative study was identified (Kenney & Clairmont, 2009). Analysis of 28 RJ conferences led the authors to question the role of

reintegrative shame in the dynamics observed. Whilst the majority of cases studied reached official resolution the analysis revealed that the conferences were a forum in which participants contested over the victim position and resolution was often reached by “winning” or “papering over” the issues. It was noted that the facilitators were volunteers and those with least skills relied largely on scripted narratives. This was contrasted with some who were more highly qualified who “sought more transformative outcomes”. It would have been interesting if the latter cases had received more detailed analysis and discussion of the processes in action. The paper provides a clear and informative analysis of the common dynamics in the conferences observed.

**Interpreting and Concluding from Studies Reviewed.** The studies reviewed highlight numerous complex and possibly confounding variables in any such research into the experience of shame. Examples are individual factors (such as race, gender, index offence), methodological factors (such as definitions and measures used) and intervention factors (such as time elapsed between offence and intervention, who is present at the intervention and who delivers the intervention). Comparison between these studies is limited due to the differences in methodologies, measures and populations studied. Two examined interventions which were not strictly RJ interventions. In the other seven studies the philosophy of RJ was adhered to, but was operationalised in very different ways, ranging from the traditional restorative conference to a group treatment program without the actual presence of a victim. Additionally facilitators had different levels of expertise and training, ranging from volunteers to specialists in forensic work. Even if such factors were addressed, services are not uniform and can vary in staff morale, staff retention, culture and results even when delivering the same training (see for example Feasey & Williams, 2009). There is an argument for not manualising restorative interventions as they are relational practices with a

rich diversity, which could be lost on manualisation. However this does render building an evidence base regarding process more problematic.

There was some evidence of shame being a key emotion experienced in RJ interventions and some links were found between the nature/management of such shame and outcomes. Negative outcomes of anger/hostility, lack of empathy and non-compliance were found to be correlated with unresolved or stigmatising shame in some studies. Positive outcomes of reduced recidivism, empathy development and compliance with boundaries were linked with reintegrative shaming in some studies. Other studies found no significant results. In practice reintegrative shaming is a combination of processes which may not lend itself to one discrete pre and post intervention measurement. Reintegrative shaming requires that the offender must first experience shame, preferably induced by the opinions of a valid reference group, and then have the opportunity to resolve the shame in order to re-identify with the values of the reference group (Braithwaite, 1989). The one study which took a qualitative approach in order to study the process found that some interventions under the umbrella of RJ do not truly adhere to the principles of restoration.

From the studies reviewed it is not yet possible to reach a coherent theory of the underlying processes of RJ although there are some indications as to the way forward. Perhaps the key area for investigation is the detail of the process including how shame is both experienced and managed.

### **Implications for Research and Practice**

There is a paucity of research examining the processes of RJ. The research which does exist does not show consistent findings although there is some support for the theory of reintegrative shaming. The attempts to measure reintegrative shaming as compared to stigmatic shaming have had limited success. The complexity and subtlety of these processes

are clearly an area for further research. There is considerable evidence that RJ can have a positive impact for stakeholders in a variety of domains (Latimer, Dowden, & Muise, 2005; Sherman & Strang, 2007), so understanding the psychological processes occurring is an area of clinical importance which remains to be clarified. The mechanism of RJ has been formulated as a transformative emotional process requiring skilled practitioners to guide and contain the process (Liebmann, 2007). RJ claims to do much more than reduce recidivism (McCold & Wachtel, 2003). Working towards an evidence base to demonstrate this will pose problems in terms of methodologies and outcome measures, as already experienced in the field of recovery (Dorrer, 2006) and forensic mental health (Fitzgerald, et al., 2010). In researching RJ interventions there is also the issue that it is not a manualised intervention and, although it can be highly scripted, it can take many different forms, thus rendering it difficult to draw firm conclusions about the element of intervention that leads to positive change. There would be value in both quantitative research examining outcome variables and also qualitative research investigating the experience of participants and the meaning and value attached to the intervention. Mixed methodologies would allow research examining the process of interventions to correlate such processes with desirable outcomes. The studies presented in this paper focus on a limited selection of index offences and it would be useful to widen this in future research, perhaps being guided by Sherman and Strang's (2007) findings regarding when RJ is most effective. It also seems pertinent to bear in mind Kenney and Clairmont's (2009) view that the processes occurring within a RJ intervention may be strongly influenced by the skill and experience of the facilitator. A potential area for future research would be the use of RJ within a therapeutic service, facilitated by practitioners with both therapeutic training and RJ training. If such a service was an in-patient therapeutic setting then the use of RJ could be viewed as a return to its original use as a community based practice. Although this has the potential for further complexities in terms of pre-existing



stigma experienced by the in-patient group, the study of therapeutic use of shame in this context could illuminate further fruitful avenues and offer a deeper understanding of RJ's potential.

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ANDY COOK BSc Hons

Section B:

A Qualitative Exploration of the Experience of Restorative Approaches in a Forensic Mental Health Setting

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A thesis submitted in partial fulfilment of the requirements of  
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CANTERBURY CHRIST CHURCH UNIVERSITY



## **A Qualitative Exploration of the Experience of Restorative Approaches in a Forensic Mental Health Setting**

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### **Abstract**

Restorative justice is an intervention gaining worldwide recognition in criminal justice systems and other settings. There is a growing evidence base demonstrating positive outcomes in a number of domains, but to date there has been no research found focussed upon the use of restorative justice in a forensic mental health setting. This study used semi-structured interviews and grounded theory analysis to explore and develop a deeper understanding of the use of restorative approaches at an early stage of implementation in such a setting, looking at the experience of the intervention, issues particular to this setting and the implementation process. The aim was to attempt to understand the underpinning psychological processes associated with the intervention and to develop a theoretical model of the use of restorative justice in the setting. There were ten participants including restorative justice facilitators, patients and the patients' staff victims. The final model highlights the role of containment and the necessity for facilitators to have a high level of skill when working with a complex, vulnerable and potentially dangerous client group. The findings are discussed in relation to theory and research with particular reference to the concept of containment. Restorative approaches are found to be congruent with models of mental health and offender recovery. Processing emotions, developing thinking and coherent narrative, and immediacy are found to be key components of the intervention. Clinical implications and limitations of the study are presented. Recommendations for further research to build upon these findings are made.



## **Introduction**

### **Restorative Justice**

Restorative justice (RJ) is an approach to justice which strives to repair harm to all parties affected by an offence or wrong-doing. There is no single definition of RJ (Johnstone & Van Ness, 2007) but rather it can be regarded as a set of principles which can be utilised in different ways according to the needs of those involved (Johnstone & Van Ness, 2007; Zehr & Mika, 1998). McCold and Wachtel (2003) state that to be fully restorative the intervention includes the victim, offender and those in the immediate ‘community of care’ although restorative approaches can be implemented in the absence of some parties if necessary. The principal stakeholders take an active role and responsibility in outlining the harm caused and constructing plans aimed at repairing harm as far as is possible. This can occur within a face-to-face encounter at a restorative conference (Walgrave, 2005) or by other means (Sherman & Strang, 2007). The role of the restorative facilitator is to maximise the potential of meaningful and restorative communication between the parties through the preparatory work and providing a structured intervention (Restorative Justice Council, 2012). Presser & Van Voorhis (2002) view the essential components of the restorative process as dialogue, relationship building and communication of moral values. Walgrave (2008) emphasises the relational aspect of RJ and the need to repair relational harm.

### **Proposed Theoretical Underpinnings of Restorative Justice**

The reported powerful transformative impact of RJ approaches has been linked to Braithwaite’s (1989) theory of reintegrative shaming. This distinguishes between what has been called “stigmatic shaming” and “reintegrative shaming”, suggesting that the former leads to the creation of an outcast group whereas the latter can reinforce moral bonds between the offender and community. Reintegrative shaming is a process in which the transgression

of boundaries and moral codes is made clear to the offender, who then has the opportunity to express remorse and make reparation for his/her harmful actions. Liebman (2007) suggests that RJ conferences are experienced as powerfully emotive. Some have argued that conferences are more likely to produce an environment conducive to change when they are attended by family or significant others whom the offender cares about, as the emotional bond will impact upon the level of shame experienced and the desire to make amends (Restorative Justice Council, 2012). The link between unresolved shame and anger/violence has been proposed to be key in understanding criminal behaviour (Gilligan, 1997). Some theoretical models place the absence of stigma and the opportunity to feel and resolve shame as key in the process of effective rehabilitation into the community (Ahmed, Harris, Braithwaite, & Braithwaite, 2001).

### **Empirical Support for the use of Restorative Justice**

RJ has been adopted as a response to crime in mainstream criminal justice systems in numerous countries around the world (Gavrielides, 2007; Hughes & Mossman, 2001; Sullivan & Tifft, 2006). There is a growing evidence base which is positive regarding the impact of RJ in a number of domains including participant satisfaction, reduced recidivism and restitution compliance for offenders, and reduced post-traumatic symptoms for victims. Bradshaw and Roseborough (2005) conducted a meta-analysis to evaluate juvenile recidivism for 11,950 young offenders in twenty-five restorative programmes. They concluded that the effect size was twice as high as that within traditional corrective programmes. Nugent, Umbreit, and Williams (2004) also conducted a meta-analysis analysing fifteen studies of nineteen restorative programmes for 9,307 young delinquents. They found that subsequent delinquency was 30% less likely than for young delinquents who had not taken part in restorative programmes. Latimer, Dowden, and Muise (2005) conducted a meta-analysis of 22 studies relating to both adult (25.7%) and young offenders (74.3%) looking at victim and

offender satisfaction, restitution compliance and recidivism. This study concluded that RJ programmes were more effective than other traditional approaches on all four indicators. Sherman and Strang (2007) systematically reviewed 16 studies which provided outcome data regarding the impact of RJ on repeat offending and effects on victim. RJ was found to reduce repeat offending for specific populations and there was consistent evidence that victims benefited from RJ interventions. They examined what the evidence suggested regarding what works for whom and concluded that RJ is most effective in cases that have a personal victim, and when the crime is violent or a burglary. There is a growing evidence base indicating that RJ is effective for both victims and offenders in crimes involving severe violence (Hayes, 2005; Strang, 2002; Sullivan & Tifft, 2006; Umbreit & Vos, 2000; Umbreit, Vos, Coates, & Brown, 2003). The majority of research to date has been with young offenders. Research examining the use of RJ with adults, and particularly in the case of violent crime, is in early stages and to date relies upon small sample sizes, and hence findings should be viewed with caution.

### **Rationale for Present Study**

There is very little literature regarding the use of RJ with people with mental health problems. Hafemeister, Garner and Bath (2012) reported that conceptually they could find no barriers to using RJ approaches with a mentally disordered population given appropriate assessment and planning, although they acknowledged the lack of empirical evidence to back up this conclusion. Garner and Hafemeister (2003) concluded from a theoretical point of view that the use of RJ interventions with mentally disordered offenders should be encouraged despite possible difficulties as the potential gains for the offender, victim and community were worthwhile pursuing. Conversely, Liebmann (2007) used a case example to illustrate that RJ was not an appropriate intervention when the offender had mental health problems but there was limited analysis provided detailing how the mental health problem

may have impacted upon the intervention. There are no outcome studies specific to the use of RJ with mentally disordered offenders and hence little knowledge about whether RJ may be a useful addition to the range of approaches available to assist in the rehabilitation of mentally disordered offenders. This study aims to begin to address these gaps through the examination of the use of restorative approaches in the early stages of implementation within a secure and forensic setting in a UK NHS trust, considering the psychological processes revealed in asking about the experience of RA. A better understanding of such processes would enable better decisions about who may benefit from the intervention and greater confidence in its use.

### **Setting**

The service consisted of community, low secure and medium secure settings, and approached treatment and rehabilitation from a perspective of ‘secure recovery’ (Drennan & Alred, 2012). There were no specific RJ pathways in place at the beginning of the research, and the research ran in tandem with the implementation process. Based upon the use of RJ in prisons there was a broad understanding that there would be two potential uses of restorative processes: either in relation to the index offence or in the running of the institution (Barabas, Fellegi, & Windt, 2012). Figure 1 illustrates this depicting the former use as “route A” and the latter as “route B”. It was unclear how these two types of intervention might differ in terms of service delivery or process. Protocol had not been established and there was a willingness to learn from accumulating experience. At the planning stages of this research no RJ interventions had taken place within the service. The mentally disordered offenders within the service are referred to as patients, and this terminology is adopted in this paper.

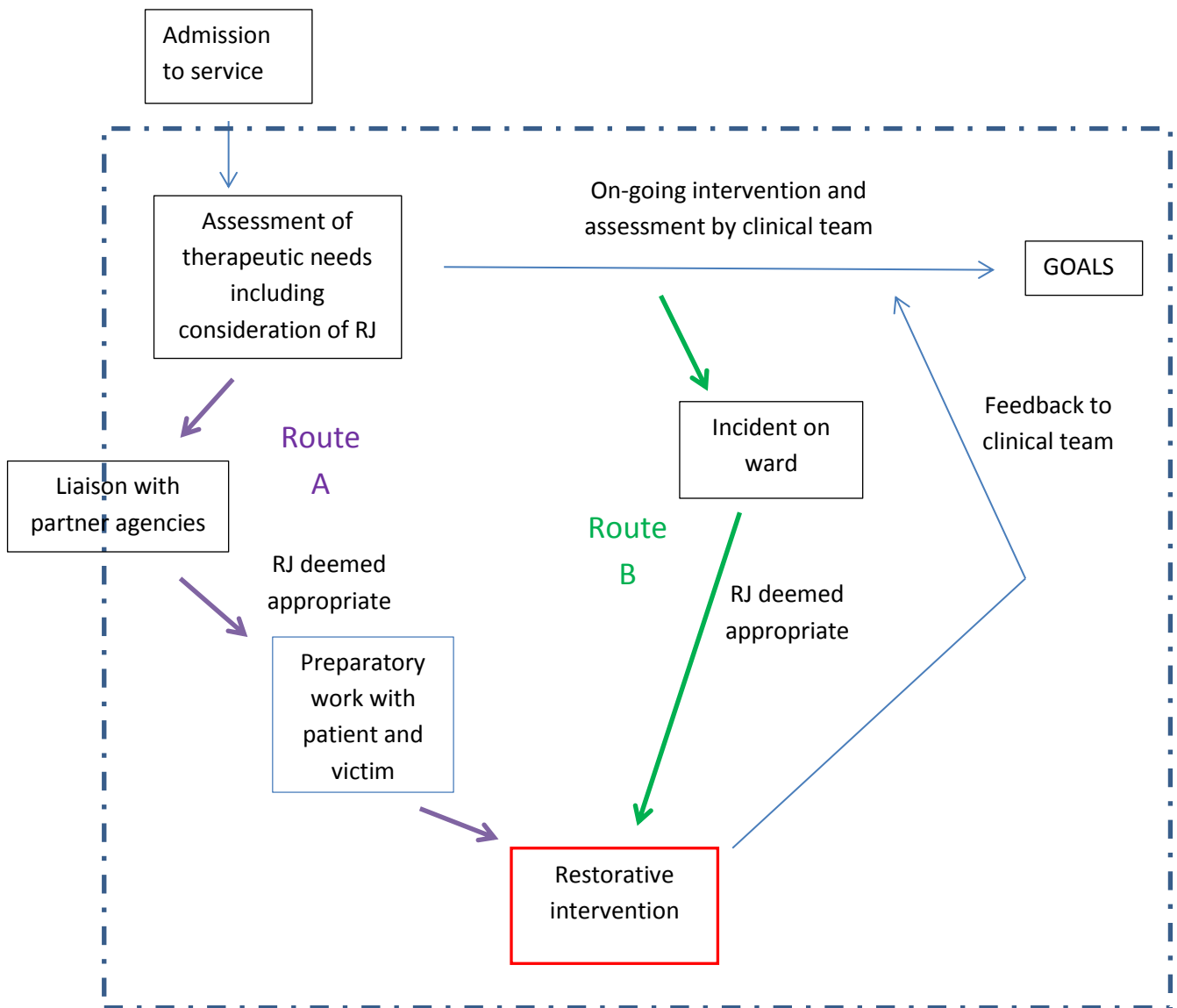


Figure 1. Model depicting two anticipated routes to a restorative intervention in an in-patient forensic mental health setting

During the course of this study the term restorative approaches (RA) was introduced in recognition of the broad range of interventions being used that had a restorative aim and also in recognition of the negative connotations that the word ‘justice’ appeared to convey to some of the patients. Both terms are used within this report with RJ referring to the more formalised and standardised practice of restorative justice conferences and RA referring to a wider spectrum of interventions including but not limited to the preparatory work conducted

with both victims and patients. For the purposes of the service and this paper RA is defined as an intervention including the processes of dialogue, relationship building and communication of moral values as outlined by Presser and Van Voorhis (2002). This definition implies the relevance of psychological processes, as interpersonal relationships are regarded the primary medium for therapeutic work and achieving mental health (Malan, 2001; Sullivan, 1940).

### **Aims and Objectives**

This study aims to consider the psychological processes revealed in asking about the experience of RA and to generate a theoretical model of the use of RA within forensic services.

### **Research Questions**

This study aims to address the following research questions:

- a. What are staff, patient and victim experiences of RA used within secure forensic services?
- b. What are the aspects of RA that are particularly suited or ill-suited to a forensic mental health setting?
- c. What has been the learning from the process of implementation of RA within a service working with mentally disordered offenders?

### **Method**

#### **Design**

The design employed was non-experimental using semi-structured interviews to generate rich data regarding the experience of RA for qualitative analysis. A semi-structured interview has a framework of themes to be explored through open-ended questions and also

allows for new questions to be generated following the participants' responses. The data collected were analysed using constructivist grounded theory methodology (Charmaz, 2006). The dearth of literature available indicated that a qualitative method such as grounded theory was an appropriate initial research approach, in order to pave the way for possible future quantitative research (Stern, 1980). This method allows for the development of inductively derived theory from the data (Willig, 2013). The development of a model from the data provides a basis for understanding the phenomenon under investigation and also a platform from which to initiate further research. A constructivist epistemology was adopted because it acknowledges that the researcher does not discover objective facts but rather actively participates in interpreting data and constructing theories from what emerges from the interrelationship and communication between researcher and participant (Charmaz, 2006). This approach provided a good theoretical fit for the exploration of a relational intervention, as opposed to an approach assuming the researcher to be a detached scientific observer discovering theory (Glaser & Strauss, 1967).

It was decided to recruit participants who had been involved in RA in the role of facilitator, patient or victim in order to gather rich data from a multiple perspective group to aid with the generation of a useful model. This was also a pragmatic decision aimed at increasing the number of potential participants given the small numbers of RA that were likely to occur during the research timescales. Gaining the multiple views of those involved in the clinical practice of RA supports the generation of an experiential account of the process and can provide a "bottom-up" explanation which helps bridge the gap between theory and practice (Kazdin, 2008).

### **Participants**

The population being studied were the staff, patients and victims of patients within the forensic service of an NHS trust.

Patients of the service had a range of severe and enduring mental health problems and personality disorders. The index offences were of a serious and grievous nature including murder, assault, sexual offences, and arson.

Victims included victims of index offences (sometimes family members, or part of the patient's social network, or sometimes strangers) and also victims of incidents on the wards (either other patients or staff members).

Staff members were qualified health and social care professionals including clinical psychologists, forensic psychologists, community psychiatric nurses and social workers. A sub-section of these staff members were trained as RJ practitioners by an accredited practitioner registered to provide such training by the Restorative Justice Council. This group of staff and the trainer (who remained involved during the implementation of the approach) were the facilitators of restorative interventions within the service.

The aim was to recruit participants from this population who had been involved in RA in the role of patient, victim or facilitator. It is possible that this subsection of the population was not representative of the whole population due to the voluntary nature of participation in RA. At the time of recruitment no RA interventions relating to index offences had progressed beyond initial planning stages and so recruitment of victims was limited to staff and patients internal to the service. Recruitment took place over two secure settings.

Ten participants were recruited via information giving and following ethical procedures as detailed below. Participants represented all three possible groups (patients, victims and RJ facilitators) and ranges of demographic information are provided in Table 1. Precise demographic data for participants is not given due to the very small sample size and the possibility of such data compromising anonymity.



Table 2

## Participant Demographic Data

Participant number	Participant group	Gender	Ethnicity	Age range	Specialism of staff	Index offence and diagnosis of patient
1	facilitator	M	White British	50-64	Psychology	
2	facilitator	F	White British	35-49	Social work	
3	victim	F	White British	35-49	Nursing	
4	facilitator	F	White British	35-49	Psychology	
5	facilitator	M	White British	50-64	Education	
6	facilitator	F	White British	35-49	Psychology	
7	facilitator	M	White British	35-49	Psychology	
8	patient	F	White British	35-49		Wounding Personality disorder Depression
9	victim	F	White British	25-34	Nursing	
10	patient	F	White British	17-24		Multiple arsons Borderline personality disorder

**Ethical Considerations**

This study received ethical approval from the local Research Ethics Committee and the local NHS Research and Development Team. Particular attention was given to the issue of consent and ensuring patients were clear that participation in the research was voluntary and not linked with recommended treatment packages or care pathways. Conduct during the study adhered to codes recommended by the British Psychological Society (BPS, 2009) and the Health and Care Professions Council (HCPC, 2012).

**Procedure**

Potential participants were initially identified by the Psychology Lead within the service who also had an overview of RA. Individuals were approached regarding the possibility of participating in the research either by this member of staff or by someone delegated with this task. Those who expressed interest were given a briefing sheet and their contact details were passed on with their permission to the researcher. In the case of patients, the initial contact was made by someone external to their treating team to aid clarity in distinguishing between voluntary participation in the research and engagement in

recommended therapeutic treatment. Additionally their capacity to consent to participation in the research was assessed by the Responsible Clinician overseeing their case. The researcher then made contact with potential participants, discussed the purpose and procedure of the study, answered any questions that were asked and obtained written consent regarding participation. Issues regarding anonymity and right to withdraw from the research were highlighted.

Participants were interviewed face-to-face. Interviews lasted between 20 and 80 minutes and were audio-recorded. The interview schedule followed was based upon the research questions although in some cases not all the questions were required as a full and rich narrative emerged in response to the first question. In other cases some supplementary questions were asked in response to answers given to aid full understanding. Some additional questions were used in later interviews as a form of theoretical sampling to move towards saturation of categories (Charmaz, 2006). Following each interview there was a verbal debriefing which included checking whether any distress had arisen during the course of the interview and answering any further questions.

Participants were referred back to their briefing sheets for details of whom to contact should they have any future enquiries regarding the research. Patients had given permission for their clinical team to be informed of their participation and were reminded that support from this team was available should they require it following interview. All patients interviewed were within secure environments and had access to 24 hour support. Victims and staff members were also linked with appropriate support networks within the workplace should they have needed support following the interview.

### **Data Analysis**

Interviews were transcribed and the data analysed using constructivist grounded theory. The data were coded in three stages in order to progress towards theory generation

from the raw data (Charmaz, 2006). Initially the first four interviews were coded line-by-line and codes closely followed the data. The second stage was to develop focussed codes which synthesised significant and/or frequent initial codes. This was not a linear process; it involved immersion in the data and reworking of ideas over time by the researcher. Lastly theoretical coding was generated, linking focussed codes and addressing the research questions. Throughout this process memos were written and used to inform the development of theory.

### **Quality Assurance**

The credibility of the data was increased through the reference to quotations from participants' transcripts in presenting research results (Williams & Morrow, 2009).

An independent coding of a section of transcript was obtained from a peer member of the Salomon's grounded theory group to provide an audit of the coding process (Elliott, Fischer, & Rennie, 1999). No major inconsistencies were identified by the researcher or peer. The coding of transcripts and emerging theoretical codes and theory were discussed with the research supervisor on a regular basis.

The researcher took part in a bracketing interview (Pezalla, Pettigrew, & Miller-Day, 2012) during the early stages of planning the research and kept a research diary throughout the research process with the aim of maintaining an awareness of personal beliefs, prejudices and hopes which may have influenced the interpretation of data.

## **Results**

The results are presented in three sections relating to the three research questions. Where possible, to illustrate codes with succinct quotes from the original data, this has been done. Theoretical codes are numbered T1-T12. The results are then translated into a model

depicting the interplay of psychological and organisational processes when RA is used in relation to an incident in a clinical environment.

### **Reported Experience of Restorative Approaches**

There was a consistent positive response from all three participant groups regarding their experience of RA.

**Powerful and positively transformative (T1).** Patients, victims and staff spoke positively of the power of the encounter in describing the face-to-face intervention. There was a focus on the immediacy of the encounter, the emotional engagement, and the communication. The opportunity to talk about the incident and the experience of being heard and understood were highlighted.

A facilitator said:

“... but to actually face the impact of what they did and to have that opportunity to just sit with [it]” (Participant 4, lines 348-352).

A victim said:

“I did feel like I'd got it off my chest and I'd been able to say what I wanted to say in a correct way. And it was definitely a good forum for that” and “A bit like I'd bared my soul...” (Participant 9, 111-113 and 233).

The containment provided by the facilitator and the structure of the intervention were described as essential in the processing of emotions and making sense of what had occurred:

“I felt very safe and I felt it was very contained and controlled. And if there had been any chink at all, it's so easy to sort of fall through or that's how it felt, feeling really fragile” (Participant 3, lines 252-254).

This powerful experience was described as leading to a subsequent change in feelings, thinking and/or behaviour, which indicated that the dialogue had impacted upon the relationships in a positive manner.

One patient who had been assaulting staff members several times per week prior to the RA said:

“...it just made me realise that peoples got families to go back to” and “I've been more thoughtful about things...” and “I didn't assault anyone [over the next 2 weeks]... I didn't want to do it again...” (Participant 10, lines 60, 148 and 168).

A victim said:

“I felt less helpless at that point” (Participant 3, line 65).

A facilitator said:

“And by the time we'd finished, I think they reflected differently on it and began to reflect on their own behaviours more than they'd ever done before” (Participant 5, lines 301-303).

**Instinctually and intellectually appealing (T2).** The idea of resolving harm through a process of communication and negotiation appeared to resonate more strongly than other possible approaches such as punishment.

One facilitator said:

“I think part of it is ridiculously straightforward, in that actually we know I think the best way to sort out any problem is to get everyone involved in the room and sit down and talk about it” (Participant 2, 309-311).

Another said:

“It asks people to take responsibility for their actions, to think about how things are going to be, how they're going to be different in future... Overall it has a much more

sophisticated, mature feel to it than a more punitive [approach]" (Participant 7, lines 216-219).

Staff members, both facilitators and victims, found that the restorative process not only appealed to personal values, but also had a good fit with therapeutic goals. Links were made with offence analysis work, victim empathy work, gaining insight, relapse prevention, reducing risk of recidivism, ability to reflect, and working towards recovery. Facilitators said:

"It fitted with what I suppose I was trying to work with, one was recognising the harmful behaviours that he'd engaged in..." (Participant 7, lines 153-154).

"...it's such an important part of someone's recovery basically, that, you know, they're able to reflect on what has happened and their kind of responsibility, and I think it's a critical part of relapse prevention" (Participant 6, 287-289).

**Generates 'converts' (T3).** All participants interviewed were enthusiastic about the model and most were impassioned regarding its use within the service even if they had some misgivings or disappointment regarding specific issues.

Victims stated:

"As regards the process itself, I would absolutely recommend it to anybody..." (Participant 3, lines 131-132).

"I think it should almost be sort of written in the policy that that's what, you know, happens after an assault" (Participant 9, lines 350-351).

A facilitator said:

"I hope it becomes something that we do as our core business really" (Participant 4, lines 478-479).

## **Factors Particular to the Setting**

**Ability of facilitators to manage complexity with high level of skill (T4).** The cases discussed were all of a high level of complexity and a variety of facilitator skills were described. These skills were linked with the processes of engagement and containment. They were also linked with complex judgements regarding assessing capacity and risk. The complexity of cases meant that facilitators needed to be flexible in their approach:

“And it actually took a slightly different route to what we intended, which was why I left it very open from the beginning” (Participant 5, lines 141-143).

Participants identified that facilitator skills were employed from the moment of first engagement and throughout the preparation period as well as during the facilitation of the face-to-face meeting. The importance of transparency and respect was highlighted. A facilitator said:

“...making sure that people that are being considered for RJ as an intervention are fully aware of what it is, what it comprises of, and are kind of almost aware of what they're letting themselves in for, and that the preparation starts even at the point that they're being thought about the potential of it” (Participant 2, lines 151-154).

All three participant groups talked about the high levels of emotion experienced over the course of the intervention and the skill needed to work with such intense emotion. Some of the emotions named were anger, frustration, shame, nervousness, humiliation and upset. Managing these emotions in a manner that enabled the participant to be heard and to make use of the approach began in the preparation stage of the intervention. A victim said:

“... what impressed me was the skill in the, doing the absolute factual bit and taking the emotion out of it. And then doing the controlled emotion, but still coming away feeling that you've been listened to” (Participant 3, lines 133-135).

Participants highlighted the importance of having trust in the facilitator's skill and knowledge:

"... I had, you know, I had faith that he would perform his role, you know, with impartiality" (Participant 8, lines 208-209).

Managing the tension between the need for knowledge of the patient, in order to assess risk and engagement, working within the organisation, and maintaining a neutral position within the RA was a recurring theme. A facilitator said:

"...actually there were aspects of this that required not simply a skill set, but a neutrality of position" (Participant 1, lines 202-203).

**The impact of mental health problems on the process (T5).** The interplay between mental health problems and the psychological process of the intervention arose in some interviews. In one case a patient was able to engage in a RA whilst he was still suffering from some symptoms of psychosis. The facilitator explained how members of the multidisciplinary team assessed that the patient had potential to make use of the intervention. He commented on the successful engagement in RA:

"Despite his mental state he was able to hear what we were saying, he apologised for his behaviour" (Participant 7, lines 30-31).

A patient who took part in a different RA said:

"I just said, I was sorry for doing that and I explained I was angry and hearing voices" (Participant 10, lines 74-75).

It was recognised that the intervention might need flexible timescales, as changing mental health needs could impact upon the capacity to cope with the intensity of the intervention and to engage meaningfully. The facilitator said of one case:

"And so from a clinical point of view, it became highly questionable as to whether or not this was the right time to be proceeding" (Participant 1, lines 263-264).



**Positioning the intervention in relation to on-going therapeutic work (T6).** When facilitators described interventions there were two clusters of factors relating to whether the intervention was related to A) the index offence or B) a ward incident.

With regards to the index offence facilitators expressed a desire to assess patients upon admission to the service in order to begin working slowly and carefully towards a RA. There was reference to developing an assessment tool to aid this process although this remained in planning stages (Lawson & Casado, 2013). It was indicated that preparation for index offence work could be lengthy taking weeks or months, including making links with victims and professionals external to the service. The complexities of this process had not been anticipated and there were still many questions such as who should make first contact with the victim and the level of knowledge and skill needed in this role. The in-house interventions had proved much easier to plan and monitor as professionals, patients and victims all fell under the jurisdiction of the service.

In relation to ward incidents, acting quickly to address a 'live' issue was seen as key, although there was emphasis put on ensuring that sufficient preparatory work was still done:

“I thought this would be a good opportunity to kind of respond quickly to what he had done” (Participant 7, lines 12-13).

There was caution given to not underestimate the complexity of RA and the skills required even when acting quickly to a ward incident:

“I think the misconception on the wards is that it's a bit of a chat, and that kind of fixes things. I don't think people have quite got the understanding of the depth of work that's sometimes needed” (Participant 2, lines 59-62).

There was recognition that incidents on wards often involve offence-paralleling behaviour which could be worked with therapeutically alongside index offence work:

“...it was very clear in parallel with his offending...” (Participant 7, line 53).

There was a clear sense that information from RA could inform care-planning and vice versa, and that there should be information exchange between professionals involved in these processes. Additionally it was viewed as essential to consider the support needs of the patient from the clinical team whilst engaging in the RA.

**Power dynamics and processes within the organisation conflicting with or confounding RA (T7).** The organisation was discussed as though it was an entity of itself beyond any individual personalities within it, and at times this entity was perceived as unhelpful to the RA. There were concerns about issues of power, authority, finances and the need to meet external targets.

In one case both a staff member and a patient were viewed as victims of mismanagement by the organisation. This led to a conference in which the organisation was represented. A facilitator hypothesised:

“it seems as if it’s not going to be possible for the organization to be neutral in mediating the daily disputes or conflicts that may happen... there may be ways in which the organization is responsible for why those two service users were at loggerheads” (Participant 1, lines 717-723).

There was a concern about coercion expressed by a member of staff and a patient. It seemed that this sense of coercion was not related to any individual misuse of power but rather in relation to the general setting in which liberty is restricted. The patient expressed hopefulness about RA but also a fear about the possible consequences of non-participation:

“I felt I had to be doing it, otherwise it would affect my discharge” (Participant 8, lines 259-260).

## **The Implementation Process**

**Change drivers (T8).** The data indicated that the implementation was largely driven by individuals. One individual in particular was referred to and several others within the pool of facilitators also emerged as taking on key roles.

The implementation was driven by a motivation to repair relationships, in the interests of therapeutic progress and/or future safety both on the ward and in society. This was expressed in personal terms by patients and victims who were interviewed. A patient said:

“... I want to have a very good relationship, you know, with [professionals]”  
(Participant 8, lines 411-412).

There was recognition of RJ having a strong evidence base in other settings and a normalisation of its use which aided acceptance of the approach within the organisation.

**Implementation enablers (T9).** The implementation enablers link directly with the positive experiences, the appeal of the model and the generation of converts outlined previously in T1, T2 and T3. The implementation generates its own momentum if nothing occurs to counteract these influences.

Staff members discussed how the culture of specific wards and pre-existing relationships could enable implementation or work against it. The importance of having time to build working positive relationships was viewed as a facilitative environment for RA.

**Implementation inhibitors (T10).** A number of factors emerged which appeared to be working against the implementation process. One inhibitor was a general sense of inertia within the organisation. As stated by one facilitator:

“... there's been a quite defensive response to the idea of doing that a bit differently, from some quarters” (Participant 7, lines 295-296).

There was a fear that that RA could make things worse. This was a strong theme, particularly in relation to the perceived vulnerability of victims, both external to the system and within the system:

“[professional] is very clearly saying we don’t want to re-traumatise the victim” (Participant 2, lines 264-265).

There was a fear of vulnerability which particularly emerged in relation to staff victims:

“...she would need to make herself vulnerable in order to explain how she felt, and she didn’t want to be doing that...” (Participant 1, lines 244-245).

“...it's a difficult thing to do as a professional with a patient, as well, because you, you know, you're not just being a professional, you're being a bit more human... you don't know whether she's sitting there thinking, ‘Ooo what a wimp’” (Participant 9, lines 107-109).

Fear of emotional vulnerability was expressed by a patient:

“Nervous...That she wouldn't forgive me” (Participant 10, lines 22-26).

One facilitator worried that there would be a pressure to react more quickly to incidents than perhaps RA would allow:

“... then I'm not sure that people who make the decisions about where the interventions will go... they're usually looking for a quicker fix than perhaps RJ represents” (Participant 7, lines 236-239).

**Processes to support psychological and organisational containment (T11).** As interventions began to be implemented it became apparent that there were a number of changes related to procedure and protocol that were helpful in supporting the process. There was an indication that anxiety and pressure experienced by facilitators was being alleviated through the addressing of these issues.

It was recognised that nursing staff had evolved their own customary practices for dealing with assaults on staff members. Introducing RA successfully would mean changing the culture on the ward to ensure that RA is held in mind as a possible way forward following incidents. A facilitator said:

“...when we start to support staff to recognise moments on the ward where something's happened, perhaps between staff or between a resident and a member of staff, where you can use an RJ model to address that ...” (Participant 7, lines 116-117).

There was an awareness of a problematic lack of accurate information about RJ within the service and those promoting the implementation had begun to address this:

“I'm going to run a session where I have an academic slot where I talk about RJ to all, 'cause there's 3 units where I work, so trying to gather the staff and sort of raise awareness, raise the profile” (Participant 4, lines 458-462).

**Challenges ahead (T12).** There was uncertainty associated with the early stages of the implementation and a sense that there was a hope for greater organisational containment once the intervention had become embedded in practice and procedure.

Maintaining skills of facilitators was a strong theme which is connected with the former theoretical code relating to facilitator skill T4. A victim who was also a staff member said:

“What concerns me is the level of training that the staff here would receive. The opportunities for them to be able to use that, to kind of mature in what they're doing and on-going training as well.” (Participant 3, lines 245-248).

There was awareness amongst staff members that there would need to be some demonstrable positive outcomes.

## **Grounded Theory Model**

The findings from the analysis of interview data have been translated into a model depicting the interplay of psychological and organisation factors. Emerging themes from the codes are placed in relation to stages in the use of RA in response to an incident in a clinical setting in which the patient is the offender and a member of staff is the victim. The central psychological theme is that of metaphorical containment which allows for the processing of overwhelming emotions, which in turn allows for the development of thinking in order to make sense of the feelings and precipitating experiences. This emerged strongly in relation to both patient and victim experience of RA. The structure of the intervention itself was experienced as containing. Containment also emerged in relation to the organisation providing a containing experience to staff, and enabling thinking rather than retreat from difficult emotions into defensive practice. Examples of the latter were avoidance of RA due to fear of vulnerability, retreat to a purely medical model of intervention avoiding thinking about the complex and painful interpersonal dynamics, and a reactive fast and/or punitive response to difficult and dangerous behaviour. In contrast, experiencing containment was described as leading to processing difficult emotions, developing narrative and dialogue, and allowing a powerful and emotive encounter to be experienced in a positive way. Fear of vulnerability was an inhibitor to progressing in the intervention. Other psychological themes are the motivation to repair relationships, experience of immediacy and the ability to form and use trusting relationships. These themes will be examined further below.

The model has parallels with and implications for the implementation process for RA in the service. It highlights the importance of the organisation providing a safe and supportive context to contain anxiety. It also highlights the impact of dynamics in staff groups on the willingness to engage in RA.

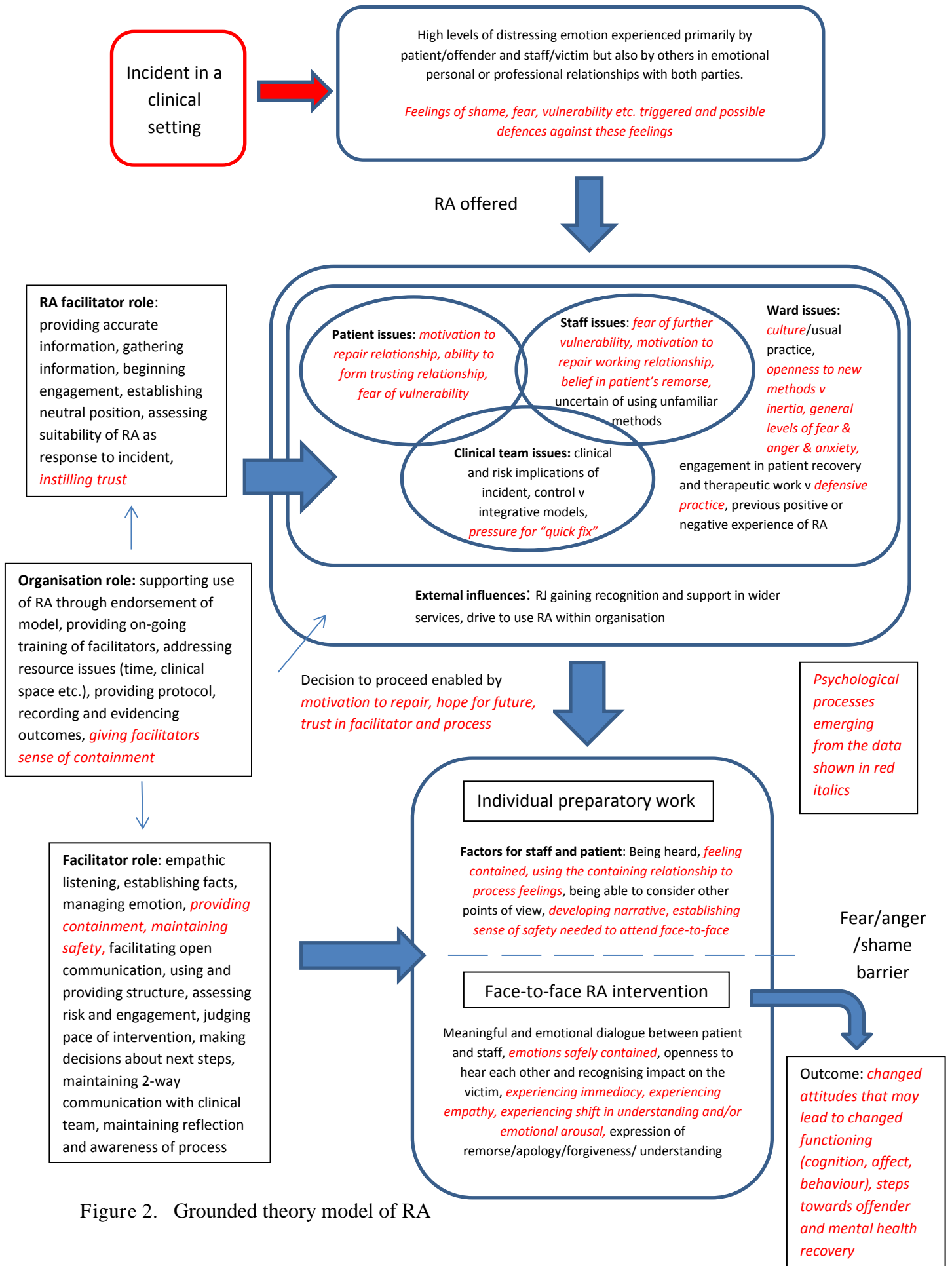


Figure 2. Grounded theory model of RA

## **Discussion**

In this section the main findings are discussed in the context of existing research and theory. Areas of clinical significance are explored, limitations of the study are considered and suggestions for future directions of research are made.

### **Reported Experience of Restorative Approaches**

The overall positive experience reported by participants was consistent with previous research which has found high levels of satisfaction from victims and offenders (Latimer, Dowden, & Muise, 2005; Liebmann, 2007; Shapland, Robinson, & Sorsby, 2011; Sherman & Strang, 2007). There was agreement across all participant groups that the components of RA provided a safe structure within which to have a psychologically meaningful encounter that seemed to bring with it an experience of being positively affected and motivation to reduce repeating the behaviours.

It was also found that the approach had an instinctive appeal to participants. The premise of a wrong leading to obligations to repair harm, and achieving this through negotiation, restitution and reconciliation resonated with childhood experiences, a personal sense of fairness, and wider cultural values. Zehr (1990) postulates that the restorative paradigm resonates with a wide range of moral and value bases which resonate with historical and/or community practices and appeal to many. It also has clear links with models of mental health recovery (Repper & Perkins, 2003) and offender recovery (Barker, 2012).

A finding in this research was the sense that RA complemented and contributed to the therapeutic goals of the service. References were made to the role of RA in working with offence paralleling behaviour (Daffern, Jones, & Shine, 2010) on the ward, raising awareness of self and others, developing victim empathy, preparing for release/discharge, improving/mending family relationships and working towards offender and mental health recovery. It seems from these results that engagement in RA incorporates some of the same



targets as therapeutic rehabilitative work within this service. However, Ward and Langlands' (2009) warning not to blend the two processes or lose one at the expense of the other remains pertinent as whilst the two processes are complementary and overlapping, the possible skills deficits and therapeutic needs of high-risk offenders would not necessarily be systematically addressed by an RJ intervention. Results of this study indicate that treatment plans could usefully incorporate RA as a supplemental approach that adds value to other aspects of rehabilitation and recovery.

### **Process of Restorative Approaches**

The factors which emerged as contributing to the powerful positive experience described were the emotional engagement of both patients and victims, the sense of safety and containment which allowed exploration of these emotions and their origins, and the immediacy of the face-to-face meeting in which meaningful dialogue occurred. These descriptions resonate with the core processes of restorative interventions as defined by Presser and Van Voorhis (2002). The strong emotions felt by both victims and patients had parallels in terms of levels of anger, fear, vulnerability, and distress. The containment experienced during the RA enabled processing of these emotions, leading to the ability to cognitively make sense of the emotional experience. The latter is a key component of offender rehabilitation (Barker, 2012) and the immediacy that RA can bring to this process appears of key importance. The therapeutic power of immediacy has been recognised in enhancing self-understanding, improving interpersonal functioning, assisting in breaking down defences and creating more realistic self-estimates (Henretty & Levitt, 2010; Kasper, Hill, & Kivlighan, 2008) and it may have parallel functions within RA.

The concept of containment and its link with clinical work is well established (Bion, 1962). The role of the facilitator which emerged from the data was to provide a safe space within which emotional arousal and defences could be regulated. The findings indicated that

facilitators' ability to provide containment was linked with their skill, the careful preparation for the intervention and confidence in the intervention. The RJ model itself was viewed as providing containment for all through its structure, momentum and focus on issues of harm. Previous research has linked positive therapeutic outcomes with the quality of the therapeutic alliance, which is in turn related to therapist ability and belief in possibility for change (Safran & Muran, 2000). Whilst RA is not framed as a therapeutic intervention, the findings indicate that a relationship of trust with the facilitator is important and suggest that a skills base with common features and underlying common principles to those employed in therapeutic work is drawn upon.

The preparatory work was found to have value in its own right. This work included many of the components discussed above in terms of containment, dialogue, processing emotions and a focus upon responsibility and harm. The opportunity to process emotions and develop a coherent narrative about experience were experienced as helpful and are processes that have been linked to psychological well-being (Bruner, 1990; Crossley, 2000). The face-to-face encounter introduced immediacy which was experienced as powerfully emotive and potentially transformative. The dialogue between patient and victim was framed as key at this stage. It possibly introduced dissonance between ideal self and self as perceived by others, giving a potential window for attitudinal change which could then lead to behavioural change (Cooper, 2007). Determining whether this occurred via a process of reintegrative shaming (Braithwaite, 1989) would benefit from more detailed examination of a greater number of interventions. It certainly seems that stigmatic shaming was successfully avoided as facilitators were regarded as benevolently neutral by all parties.

There are many factors which could contribute to changed functioning which are not unique to the RA process. The willingness to engage in the intervention could be indicative of a readiness to change (Prochaska & DiClemente, 1983). The enthusiasm of the staff

involved in the implementation of RA could have impacted positively upon the patient experience and the consequent establishing of rapport with both parties, which is considered to be a crucial contributor to outcome in psychotherapeutic interventions (Roth & Fonagy, 2006).

### **Factors Particular to the Setting**

One of the strongest findings of this research was the high level of skill required by practitioners facilitating the interventions. This was possibly influenced by the high proportion of facilitators in the sample, but it did emerge in some form from every interview undertaken. This is perhaps not a particularly surprising finding in a context where all cases are complex due to the mental health needs of the patients, the history of offending, and risk-factors which have necessitated a secure environment. Perhaps a greater degree of skill is required in successfully delivering RA with such a complex and vulnerable client group. There was a sense of fragility to the process that needed skill and judgement to negotiate in a responsive and flexible manner. There was an indication of maintaining a balance between an honest conveyance of the harm caused to the victim and maintaining safety for all. Leaning too far in the former direction may have realised the fears of causing more harm, whereas erring on the side of safety may have lost the sense of immediacy and positive impact of the intervention. With a psychologically vulnerable and potentially dangerous client group adverse outcomes could have serious implications in terms of damaging on-going rapport and increasing risk.

Others have reported that under-skilled facilitators can be left reliant upon scripted narratives which do not lead to transformative outcomes and can lead to increased anger and resentment (Kenney & Clairmont, 2009). Umbreit, Bradshaw and Coates (1999) investigated use of RJ approaches in cases of severe violence and similarly found that the work had a high level of emotional intensity, needed longer preparation and required advanced training for the

facilitators. They noted the need for a non-judgemental attitude which could be likened to the reference to neutrality in the results of this research. Again there are parallels with therapeutic work in the creation of a non-judgemental environment (Rogers, 1951).

On-going relationships between staff and patients within the organisation were a complex issue in relation to RA. For the facilitator having a positive working relationship with the patient was viewed as useful in terms of assessment and trust but a hindrance in terms of possible perceived alliances or potential to encumber future therapeutic work. Results indicated that environments in which there were longer term positive relationships in place between staff and patients were viewed as more suitable for RA. The therapeutic relationships already in place in the setting perhaps provided a template from which patients were able draw upon in order to form the necessary therapeutic alliance with the RA facilitator. Additionally the experience of a therapeutic ward environment in which relational security principles (Department of Health, 2010) are employed perhaps contributed to the motivation to mend working relationships which had been developing.

The process offered by RA to mend relationships was approached with some trepidation by both patients and staff. Fear of vulnerability in relation to the face-to-face encounter was expressed by both groups. For staff victims this presented dilemmas about levels of self-disclosure and stepping out of their usual role. The role of the professional self can offer some emotional protection and sense of control in a challenging environment (Taylor, 1998) so it was not surprising that nursing staff were concerned with self-preservation and maintenance of identity when considering interacting in a more personal and equal manner with patients. This was compounded by the fact that they would be required to talk about emotive issues of feeling vulnerable and being harmed. For patients there was fear of emotional vulnerability in facing up to wrong-doing and being judged for this. This seems to indicate that there was a feeling of guilt or shame and an awareness of potential stigma.

## **Organisational Implementation Issues**

Participants expressed the view that the use of RJ/RA depended upon established protocols to create psychological containment for an anxiety inducing intervention. They wanted clear information to inform decisions and to dispel fantasy. They needed support to recognise when a philosophy of face-to-face conciliation could be useful, in an organisational culture where this type of psychological contact is seen as risky and potentially dangerous. They wanted reassurance that facilitators would have the necessary skills to maintain safety.

When a staff member is subjected to an assault on the ward in a high risk environment there is likely to be an emotional response from staff of fear, anxiety and anger, with the possibility of defensive practices being deployed in the system in order to tolerate the anxiety (Menzies Lyth, 1960, 1988). RA perhaps offers an alternative to defensive practice, as results indicate it promotes a holistic encounter which mitigates against fragmenting the patient's recovery needs. However, RA is likely to be avoided if sufficient containment is not experienced on multiple layers for all those involved.

## **Limitations of the study**

This research was based upon a very small sample and caution is recommended in generalising results. The majority of the participants were RJ facilitators which may skew findings.

The sampling strategy which included initial self-selection for the RA intervention followed by agreeing to participate in this study may have introduced bias towards a sample with more positive experiences of RA than may be the case for the wider population of staff and patients in the service. Additionally, those staff members who put themselves forward to be trained as facilitators are perhaps not surprisingly enthusiastic about the model. The lack of any negative voices about restorative interventions was possibly a result of this bias.

The study is limited by the lack of triangulation of data and participant validation.

Both the researcher and the lead supervisor were working within the service during the research study, and both were involved to different degrees in the implementation of RA in the organisation. This may have had an impact upon objectivity, as the research itself demonstrates that exposure to RJ can result in extreme enthusiasm for the model.

The study was also limited by the stage of the implementation process. The unforeseen degree of complexity involved in undertaking a restorative intervention for an index offence meant that the research was limited to RA interventions relating to ward incidents.

### **Further Research**

Further research is recommended to expand upon the small number of participants in this study and to expand upon the areas of exploration. There is still much to be explored about the process and effect of restorative interventions within therapeutic settings. It will be important to examine restorative interventions with index offences when they are initiated. It would be perhaps useful to include participants who choose not to engage in restorative approaches as well as those who do engage in order to gain a more balanced picture. Qualitative methodologies are likely to be suited to exploration of process whereas quantitative methodologies are appropriate for outcome evaluation. Mixed methodologies could explore links between process and outcome. Longitudinal studies could examine whether outcomes are retained over time. A further research area is whether restorative justice outcomes are related to mental health diagnosis, as it could be hypothesised that differing mental health symptoms will mediate the psychological process associated with RJ in differing ways. Further, research could develop the emerging model proposed in this paper.

## **Conclusion**

This exploratory study examined the use of restorative approaches within a forensic mental health setting. The study provides a basic model of the interplay between organisational and psychological factors when RA is used in response to an incident in a clinical setting. The concept of containment is discussed in relationship to this model. The findings indicated a positive experience of RA on a number of different levels for all stakeholders. The findings emphasise the need for RA facilitators to have a high level of skill in order to manage the complexity of the cases and to progress the interventions in a safe and meaningful manner. The original goal of the service was to implement formal RJ interventions. In the process of working towards this RA was found to be valuable in its own right. Psychological impact of processing emotions, developing thinking and coherent narrative, and the effect of immediacy are highlighted. Although there are some methodological limitations to the study the model contributes to the limited knowledge base regarding the process of restorative interventions.

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ANDY COOK BSc Hons

Section C:

Critical Appraisal

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A thesis submitted in partial fulfilment of the requirements of  
Canterbury Christ Church University for the degree of  
Doctor of Clinical Psychology

OCTOBER 2013

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## Critical Appraisal

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**1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?**

Undertaking this research project has been a learning experience from start to finish in a large number of areas, including the initial conceptualisation of the project, the ethics approval process, participant recruitment, undertaking the interviews and analysing the results. I feel have developed considerable skills and knowledge regarding the research process as I was relatively naïve to the area at the beginning of the project.

The initial challenge was to narrow down a broad area of potential research to a feasible size and to decide upon a research methodology. I was aware that previous research examining restorative justice had used both quantitative and qualitative methods, and had considered outcomes for offenders and victims. As I developed my understanding both of the restorative justice process and also the service context where I would be conducting my research, I was able to begin to make decisions about how to focus my research. Developing appropriate research questions was key. A question examining whether the intervention ‘worked’ would have indicated a quantitative method analysing outcome data. I wanted to explore the experience of restorative justice interventions in the setting a number of reasons;

it was likely that the potential participant pool would be too small to generate statistically significant outcome data, there was little prior information regarding this specific topic and also I was drawn to the idea of generating rich data from interviewing participants. Thus a quantitative method was indicated. I needed to develop my understanding of the possible methodologies in order to decide upon grounded theory as the methodology which would best allow exploration not only of direct experience but also clinicians' understanding of patients' experience, whereas other methods such as interpretative phenomenological analysis focuses upon personal lived experience. Additionally grounded theory was best suited to exploring the relationships between theoretical constructs and leading to the possibility of developing a model to illustrate such relationships.

I then needed to consider my epistemological position in thinking about how the research would be conducted. I had to decide whether to adopt a realist stance which would place me as a discoverer of the truth (Glaser & Strauss, 1967) or a constructivist stance which would place me in active role of constructing meaning with participants (Charmaz, 2006). The latter provided a better fit both with my own epistemological position regarding how we make sense of experience and also with the subject matter which was the exploration of a relational intervention. I was aware that this stance placed a responsibility on me to maintain an awareness of my own potential bias and this was something that I tried to do through the use of a bracketing interview and research diary. As the project progressed my understanding of the influence of my own assumptions increased, such as the part that such assumptions played in the construction of the research questions. This was particularly apparent to me when I began to analyse the data in relation to the research questions.

The next challenge was the NHS ethics approval process which was both arduous and instructive. I took my research proposal to panel twice as initially I had not provided enough detailed information regarding the range of mental health problems in the participant

population, the recruitment process or capacity to consent. The attention to detail which was required was difficult to achieve at a point when I was still somewhat unfamiliar with the forensic setting, but was very useful when it came to beginning the research process. By the time I attended the second panel I felt much better informed and was able to talk confidently and competently about the project. Even so, it was not until I actually made arrangements to interview a patient that I realised that digital recorders are contraband items on secure units, and I needed to contribute to thinking about a risk assessment and protocol for bringing one onto the ward.

I gained some insight into the task of recruitment and the potential obstacles to this process. For me the greatest frustration was the very small population of potential participants due to the limited number of restorative justice interventions that had taken place. I was fortunate in that many of the people who had participated in a restorative approach were keen to talk about it. I enjoyed conducting the interviews and believe I gained competence in asking questions in a neutral manner whilst following the lead of the participants. I used the recursive iterative approach advocated by grounded theory methodology to modify later interviews to explore some concepts from earlier interviews in more depth, such as the idea of facilitator neutrality and the two different uses of restorative approaches within the organisation.

One of the steep learning curves for me was the analysis of the data. The interviews produced much rich data and I was initially uncertain how to begin the process. I was somewhat cynical about applying line-by-line coding (Charmaz, 2006) as it seemed evident that some lines could not be coded outside the context of neighbouring lines or even the whole paragraph. However, I went ahead with this method and found it to be an excellent technique for focussing upon and sticking closely to the data. In developing theoretical codes I was unsure how much to be guided by my research questions. In some ways these



questions provided a welcome framework and yet it was here that I felt that my preconceived ideas were possibly impacting upon findings in a possibly restrictive manner. When I translated the data to a process model which was informed by thinking about the interplay of psychological and organisational processes the data was synthesised in a less restrictive manner.

Retaining a critical stance throughout the research process has been a challenge. The restorative justice approach appeals to my value base and belief system. Additionally, it was at times difficult to retain an independent position meta to the organisation and the implementation process as I began a clinical placement within the organisation during the research process. My lead supervisor was in a similar position as he worked within the organisation and played a prominent role in the restorative justice implementation process. The importance of critical reflective space and independent feedback has been a major learning experience of undertaking this research. It has been invaluable to have support in questioning some assumptions I made unintentionally.

Upon completion of this project I believe my qualitative research skills have a solid base which can be expanded upon in the future. My quantitative research skills remain at a basic level and largely unpractised.

**2. If you were able to do this project again, what would you do differently and why?**

I now have a greater understanding of grounded theory methodology, restorative justice and the forensic mental health context, all of which would impact upon how I might conduct this project differently.

If I were to begin again I would like to have only one quite open research question as I felt that having three different questions detracted from focussing solely on what arose from the data, and instead to some degree imposed an external structure on the findings. This structure initially guided me to consider the organisational processes rather than the psychological processes. Whilst I agree with the more recent grounded theory researchers who state that the researcher is not neutral and will have influential interests and hypotheses (Charmaz, 2006, Henwood & Pidgeon, 1996) I do believe that I could have generated a less leading or constraining research question or a research question that led more directly to psychological theory. The wording of the research question would have been dependant upon the stage of the restorative approaches implementation process and my knowledge about its progress and ideally would have been solely related to participants' personal experience of the intervention and their perception of patient's experience of the intervention.

Additionally, at the time of planning the research I was not aware of the importance of the role of supporters in restorative interventions. With hindsight I would have planned to interview supporters as a fourth data source. Also, given that one finding was regarding the importance of two-way communication between the restorative facilitator and the clinical team, it may have been valuable to interview a lead professional from the patient's clinical team following a restorative intervention. These further sources of information could have increased the credibility of the findings (Kimchi, Polivka, & Stevenson, 1991).

Perhaps, given the early stage of the implementation, it would have been wise to only interview practitioners and to focus the research upon the implementation process. This tighter focus may have aided saturation of categories (Corbin & Strauss, 2008) relating to the implementation process but would have lost the perspective of patients relating to the experience of the intervention.

Certainly, with hindsight I could have approached some of the more practical planning tasks more efficiently and rigorously such as preparing for ethical approval and anticipating the need to risk assess the use of a digital recorder.

**3. Clinically, as a consequence of doing this study, would you do anything differently and why?**

As a consequence of hearing the positive experiences of restorative interventions I would feel more confident regarding advocating the approach within a forensic mental health setting. As part of the preparation for this research I undertook the training in restorative justice facilitation, and hearing the positive experiences and the potential of the intervention inspires me to put what I have learnt into practice. I would hope that I would be alert to some of the lessons learnt by others such as the importance of preparatory work and the importance of two-way communication with the clinical team. I am also more consciously aware of sharing some of the anxiety expressed about the possibility of ‘making things worse’ and my potential to avoid engaging in such a powerful intervention.

**4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?**

I believe there is scope for further grounded theory research exploring participants’ experience of the intervention, particularly when it begins to be implemented in relation to index offences. At the beginning of this project I envisaged that the implementation of restorative approaches would have progressed much further by the time I was recruiting and interviewing. I imagined that restorative conferences relating to index offences would be

occurring and that I would be able to recruit from the facilitators, patients and victims who were subject to such conferences. My back-up plan, if this was not the case, was to interview staff about the implementation process and try to make sense of why conferences were not occurring. What I found myself doing was a mixture of the two, as some restorative interventions had occurred relating to ward-based incidents and some planning of restorative interventions relating to index offences had occurred. This was a pragmatic way forward given the very early stages of the implementation and the limited numbers of potential participants. I would like to conduct further research at a later stage in the implementation with the possibility of greater numbers of patient participants and the inclusion of external victims.

There is certainly scope for a variety of further research examining not only experience but also whether the intervention works and pursuing some of the ideas regarding how it works. The former would involve outcome measures, a quantitative methodology and a longer timescale to allow for follow-up data to be collected. Possible outcome data could be related to recidivism rates, mental health symptoms, attitudinal change and satisfaction ratings for the patient, and satisfaction ratings, post-traumatic stress symptoms, quality of life measures and attitudinal change for the victim, as demonstrated by previous research in other settings (Gavrielides, 2007; Latimer, Dowden, & Muise, 2005; Marshall T. , 1999; Shapland, Robinson, & Sorsby, 2011; Sherman & Strang, 2007). The latter task of exploring how the intervention works could be explored via further grounded theory study using semi-structured interviews with patients who had taken part in restorative interventions.

Of these possibilities the latter holds more appeal for me as it would build upon skills I have gained in undertaking this research and would build upon some of the findings in this research regarding the powerful emotional immediacy experienced in the face-to-face interventions which occurred. It would be ideal to have the luxury of longer timescales to

allow for follow-up interviews some months after the intervention and also respondent validation after analysis of the data (Charmaz, 2006).

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Section D:

Appendices

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## Appendix 1

### Search Strategy for Section A

## Appendix 1

### Search Strategy for Section A

The databases PsycINFO, ASSIA, Web of Science, Social Policy and Practice, and Cochrane Database of Systematic Reviews were searched using the search terms “restorative justice” AND “shame OR guilt OR therapeutic change OR therapeutic process OR psychotherapeutic process OR psychotherapeutic techniques”. Searches were limited to 1986 to 2013 as the term restorative justice was not used prior to 1986. Papers were limited to peer reviewed journals in English language. Numbers of papers identified are displayed in the table below.

	Number of papers identified
PsychINFO	28
ASSIA	8
Web of Science	51
Social Policy and Practice	7
Cochrane Database	0

Abstracts were searched manually for studies examining the process of restorative justice approaches for the offender. This included studies which aimed to investigate the differential impact of reintegrative shaming and stigmatising shaming, and also studies which

proposed to investigate the process of a restorative justice intervention as defined by Presser & Van Voorhis (2002).

Studies related to the use of shaming in parenting were excluded on the basis of the confounding variables this would introduce due to the breadth of family culture and functioning. Studies requiring participants to reflect on hypothetical situations were excluded on the basis of ecological validity.

Nine studies were identified which met these criteria and all nine are discussed.

## Appendix 2 Quality rating of studies

study	Aim of study clear	Ethics addressed	Representative sample	Study design	Confounders/researcher impact	Measures appropriate	Results clear and believable	Usefulness	Rating
Makkai & Braithwaite 1994	Yes 2	Partial 1	Yes 2	T1-T2 design 2	Partial 1	Yes 2	Yes 2	Yes 2	14/16
Harris 2003	Yes 2	No (existing data) 0	Yes 2	RCT 2	Not considered 0	Yes 2	Yes 2	Yes 2	12/16
Harris 2006	Yes 2	Consent only (existing data) 1	Yes 2	RCT 2	Not considered 0	Yes 2	Yes 2	Yes 2	13/16
Tyler et al. 2007	Yes 2	No (existing data) 0	Yes 2	RCT 2	Partial (quality of intervention) 1	Yes 2	Yes 2	Yes 2	13/16
Murphy & Harris 2007	Yes 2	Yes 2	60% response 1	Survey 2	Not considered 0	Yes 2	Yes 2	Yes 2	13/16
Roseman, Ritchie & Laux 2009	Yes 2	Yes 2	Very small sample 0	Non-random allocation to groups. No control group. 1	Previous treatment 1	Validity and reliability? 1	Lack of statistical power 1	Basis for further research 2	10/16
Jackson 2009	Yes 2	Yes 2	Small sample for heterogeneous population 1	T1-T2 design 2	Confounders considered 2	Yes 2	Not clear 1	Basis for further research 2	14/16

Loeffler, Prelog, Pabba Unnithan & Pogrebin 2010	Yes 2	Yes 2	Yes (although somewhat small) 2	Non-random allocation to groups 1	Demographic details given and confounders considered 2	Yes 2	Yes 2	Yes 2	15/16
Kenney & Clairmont 2009	Yes 2	Yes 2	Yes (with some limitations) 2	Qualitative open coding 2	No researcher reflexivity discussed 0	Yes 2	Yes 2	Yes 2	14/16

Scores for each factor are:      0 = weak      1 = moderate      2 = strong

### Appendix 3

#### Participant Demographic Data

Participant number	Participant group	Gender	Ethnicity	Age range	Specialism of staff	Index offence and diagnosis of patient
1	facilitator	M	White British	50-64	Psychology	
2	facilitator	F	White British	35-49	Social work	
3	victim	F	White British	35-49	Nursing	
4	facilitator	F	White British	35-49	Psychology	
5	facilitator	M	White British	50-64	Education	
6	facilitator	F	White British	35-49	Psychology	
7	facilitator	M	White British	35-49	Psychology	
8	patient	F	White British	35-49		Wounding Personality disorder Depression
9	victim	F	White British	25-34	Nursing	
10	patient	F	White British	17-24		Multiple arsons Borderline personality disorder

## Appendix 4

### List of RJ interventions discussed by participants

	Incident	RJ work undertaken	Further RJ work planned
1	Complaint made by patient about staff behaviour. Developed into an understanding of both being victims of mismanagement.	Individual work with patient and staff. Conference between staff member and another member of staff representing the organisation.	Possibility of progressing further by indirect means between patient and staff member as one party was currently unwilling to meet face to face
2	Index offence of stalking	Request for RJ by patient assessed as inappropriate	None
3	Alleged assault of patient by staff (no witnesses and denied)	Individual work with staff member	Decision not to go ahead as one party was unwilling to have conference
4	Inappropriate sexual behaviour towards member of staff by patient (witnessed and admitted)	Face-to-face impromptu RJ intervention with little preparatory work	No further work planned as aim was achieved
5	Assault of member of staff by patient (witnessed and admitted)	Individual work with victim and patient, including information exchange between two processes	Decision not to proceed to conference as one party was unwilling
6	Index offence of offending against own children	Individual work with patient	Possibility of progressing further
7	Index offence of murdering partner	Individual work with patient	Possibility of progressing further
8	Index offence of violence against ex-partner	Individual work with patient, discussions with VLO	Decision not to go ahead due to concern about impact upon victim
9	Index offence of violence towards father	Individual work with patient	On hold due to change in patient's mental health condition
10	Assault of member of staff by patient (witnessed and admitted)	Face-to-face impromptu RJ intervention with some preparatory work	No further work planned as aim was achieved

## **Appendix 5**

### **Health research authority approval letter**

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## **Appendix 6**

### **Research and development approval letter**

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## **Appendix 7**

### **Participant information sheets**

#### **Looking at the Implementation of Restorative Justice Approaches Participant Information Sheet 1 (for service users)**

We would like to invite you to take part in our research study. This research study is being undertaken as part of my doctorate qualification in clinical psychology at Canterbury Christ Church University. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have.

Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear

#### **Part 1**

##### **What is the purpose of the study?**

Restorative justice (RJ) is an approach that is gaining recognition as having a positive impact for the victim, offender and community. RJ is concerned with repairing harm rather than only inflicting punishment for a crime. RJ approaches are being used in a variety of settings and research is being undertaken to determine the impact and effectiveness of these approaches. This study aims to specifically look at the implementation of RJ approaches with offenders who also have mental health problems. Greater knowledge in this area will help inform what works with this population and will aid the provision of future services.

##### **Why have I been invited?**

You have been chosen because you have been offered the opportunity to be involved in a RJ intervention. An aim of this study is to gain the views of all those involved in the RJ process. This study is totally separate from the RJ intervention itself. This study is interested in your experiences of the RJ intervention but is not part of the RJ intervention.

##### **Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a

consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

### **What will happen to me if I take part?**

A time will be arranged for you to be interviewed by the researcher. You may be interviewed twice. You will be interviewed about your experience of the RJ process shortly after the intervention and again some months later. These interviews will take between 30 minutes and 1 hour, and will be audio recorded. The interview will take place in a private room on NHS premises where you are receiving care. You will be asked about your views, feelings and experience of the RJ intervention which you took part in. There are no right or wrong answers – the study is interested in your experience of the intervention, whatever that was.

If you take part in the study then Dr Gerard Drennan, will access your medical records and will pass on some demographic information about you to the researcher. This will be your gender, ethnicity, age, diagnosis and the crime committed.

### **What are the possible disadvantages and risks of taking part?**

It is possible that it may be upsetting to be interviewed about the RJ process. If it becomes too difficult to carry on at any point you can decide to end the interview

### **What are the possible benefits of taking part?**

The knowledge gained from the study may help improve the implementation of future RJ procedures. You will be able to contribute your views about RJ.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

All documents and recordings related to the study will be kept in a locked filing cabinet and only the researchers will have access to them. No-one outside the study will know the names of the participants. The interviews and questionnaires will not be linked directly to people's names. People's names and consent forms will be kept separately from the interview and questionnaire data. Data will be stored with a number and not with people's names attached. The only circumstances in which information from interviews would be passed on to relevant professionals would be if anyone is believed to be at risk, or if previously undisclosed offences are referred to.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You are free to decline to take part or to withdraw from this study at any time prior to the study being completed, without having to give a reason.

### **What if there is a problem?**

Please talk with your keyworker or another member of staff if you feel upset about the study or if you wish to talk further about the RJ process.

If you remain unhappy and wish to complain formally, you can do this by contacting:

Paul Camic, Professor of Psychology and Research Director  
Department of Applied Psychology  
Canterbury Christ Church University  
Broomhill Road  
Tunbridge Wells, Kent TN3 0TG.  
Tel: 01892 507 773

### **What will happen to the results of the research study?**

It is intended to publish this study for scientific purposes. Your identity will not be revealed in any publications.

### **Who is organising and funding the research?**

I am Andy Cook, a trainee clinical psychologist. I will be supervised by Dr. Gerard Drennan, \*\*\*\* Trust, and Prof Paul Camic, Canterbury Christ Church University.

### **Who has reviewed the study?**

All research in the NHS is approved by an independent group of people called a Research Ethics Committee. This is to protect your safety, well-being, rights and dignity.

### **Further information and contact details**

If you have any further questions about the study please contact Dr. Gerard Drennan via Deborah Nicholls on telephone number: 01323 444185.

**Looking at the Implementation of Restorative Justice Approaches  
Participant Information Sheet 2  
(for victims)**

We would like to invite you to take part in our research study. This research study is being undertaken as part of my doctorate qualification in clinical psychology at Canterbury Christ Church University. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have.

Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear

### **Part 1**

#### **What is the purpose of the study?**

Restorative justice (RJ) is an approach that is gaining recognition as having a positive impact for the victim, offender and community. RJ is concerned with repairing harm rather than only inflicting punishment for a crime. RJ approaches are being used in a variety of settings and research is being undertaken to determine the impact and effectiveness of these approaches. This study aims to specifically look at the implementation of RJ approaches with offenders who also have mental health problems. Greater knowledge in this area will help inform what works with this population and will aid the provision of future services.

#### **Why have I been invited?**

You have been chosen because you have been offered the opportunity to be involved in a RJ intervention. An aim of this study is to gain the views of all those involved in the RJ process. This study is totally separate from the RJ intervention itself. This study is interested in your experiences of the RJ intervention but is not part of the RJ intervention.

#### **Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the management of the criminal case or support you may be receiving

#### **What will happen to me if I take part?**

A time will be arranged for you to be interviewed by the researcher. You will be interviewed about your experience of the RJ process shortly after the intervention. The interview will take approximately 1 hour, and will be audio recorded. The interview will take place in a private environment either on NHS premises, or if you would prefer, at your home. You will be asked about your views, feelings and experience of the RJ intervention which you took part in. There are no right or wrong answers – the study is interested in your experience of the intervention, whatever that was.

### **What are the possible disadvantages and risks of taking part?**

It is possible that it may be upsetting to be interviewed about the RJ process. If it becomes too difficult to carry on at any point you can decide to end the interview

### **What are the possible benefits of taking part?**

The knowledge gained from the study may help improve the implementation of future RJ procedures. You will be able to contribute your views about RJ.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

All documents and recordings related to the study will be kept in a locked filing cabinet and only the researchers will have access to them. No-one outside the study will know the names of the participants. The interviews and questionnaires will not be linked directly to people's names. People's names and consent forms will be kept separately from the interview and questionnaire data. Data will be stored with a number and not with people's names attached. The only circumstances in which information from interviews would be passed on to relevant professionals would be if anyone is believed to be at risk, or if previously undisclosed offences are referred to.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You are free to decline to take part or to withdraw from this study at any time prior to the study being completed, without having to give a reason.

### **What if there is a problem?**

Please talk with your victim liaison officer if you feel upset about the study or if you wish to talk further about the RJ process.

If you remain unhappy and wish to complain formally, you can do this by contacting:

Paul Camic, Professor of Psychology and Research Director

Department of Applied Psychology

Canterbury Christ Church University

Broomhill Road

Tunbridge Wells, Kent TN3 0TG.

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### **Further information and contact details**

If you have any further questions about the study please contact Dr. Gerard Drennan via Deborah Nicholls on telephone number: 01323 444185.

**Looking at the Implementation of Restorative Justice Approaches  
Participant Information Sheet 3  
(for staff)**

We would like to invite you to take part in our research study. This research study is being undertaken as part of my doctorate qualification in clinical psychology at Canterbury Christ Church University. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have.

Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear

### **Part 1**

#### **What is the purpose of the study?**

Restorative justice (RJ) is an approach that is gaining recognition as having a positive impact for the victim, offender and community. RJ is concerned with repairing harm rather than only inflicting punishment for a crime. RJ approaches are being used in a variety of settings and research is being undertaken to determine the impact and effectiveness of these approaches. This study aims to specifically look at the implementation of RJ approaches with offenders who also have mental health problems. Greater knowledge in this area will help inform what works with this population and will aid the provision of future services.

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#### **Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not have any impact on your employment.

#### **What will happen to me if I take part?**



A time will be arranged for you to be interviewed by the researcher. You will be interviewed about your experience of the RJ process shortly after the intervention. The interview will take approximately 1 hour, and will be audio recorded. The interview will take place in a private room at your place of work. You will be asked about your views, feelings and experience of the RJ intervention which you took part in. There are no right or wrong answers – the study is interested in your experience of the intervention, whatever that was.

### **What are the possible disadvantages and risks of taking part?**

It is possible that it may be upsetting to be interviewed about the RJ process. If it becomes too difficult to carry on at any point you can decide to end the interview

### **What are the possible benefits of taking part?**

The knowledge gained from the study may help improve the implementation of future RJ procedures. You will be able to contribute your views about RJ.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

All documents and recordings related to the study will be kept in a locked filing cabinet and only the researchers will have access to them. No-one outside the study will know the names of the participants. The interviews and questionnaires will not be linked directly to people's names. People's names and consent forms will be kept separately from the interview and questionnaire data. Data will be stored with a number and not with people's names attached. The only circumstances in which information from interviews would be passed on to relevant professionals would be if anyone is believed to be at risk, or if previously undisclosed offences are referred to.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You are free to decline to take part or to withdraw from this study at any time prior to the study being completed, without having to give a reason.

### **What if there is a problem?**

Please talk with your supervisor if you feel upset about the study or if you wish to talk further about the RJ process.

If you remain unhappy and wish to complain formally, you can do this by contacting:

Paul Camic, Professor of Psychology and Research Director

Department of Applied Psychology

Canterbury Christ Church University

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## **Appendix 8**

### **Interview schedules**

#### **Interview Schedule Patient**

Could you describe the RJ process that you have been through?

What was your experience of the RJ process?

How did you feel in relation to how you were treated?

What were your feelings about the process in general?

What worked well for you and what could be improved?

Were there any surprises or regrets?

How if at all have your thoughts and feelings about what you did changed since the restorative justice intervention?

What influenced your decision to take part in the RJ process?

Is there anything else you think I should know about to understand your experience better?

What is your view regarding the use of RJ in this service? How does it compare to other practices?

Can you say some more about that?

What are your hopes for the future and has the RJ process had any impact on this?

What motivated you to take part in this study?

## **Interview Schedule Victim**

Could you describe the crime/incident and the RJ process?

What was your experience of the RJ process?

How did you feel in relation to how you were treated?

What were your feelings about the process in general?

What worked well and what could be improved?

Were there any surprises or regrets?

What were your hopes for the RJ process and have these been realised at all?

Were there any hopes in relation to the offender?

What is your view of RJ as compared to other practices (such as punishment)?

Can you say some more about that?

Is there anything else you think I should know about to understand your experience better?

What motivated you to take part in this study?

## **Interview Schedule Facilitator**

Could you describe the RJ process you were involved in?

(How was it referred, what was the preparation, what were the timescales, how did it end, did it go to conference etc?)

What happened next?

What was your experience of the RJ process?

What were your feelings about the process in general?

What worked well and what could be improved?

Were there any surprises or regrets?

What has been the impact of the RJ process?

Was it helpful in any way or not?

What have you noticed if anything that is different since the intervention?

What were your hopes for the RJ process if any, and have these been realised at all?

Were there any hopes in relation to the offender?

What is your view of use of RJ in this service?

Can you say some more about that?

What does RJ mean to you?

What have you learnt from this experience?

Have you got anything else you would like to say about the implementation process of RJ in this service?

What has and hasn't been going well?

Is there anything else you think I should know about to understand your experience better?

What motivated you to take part in this study?

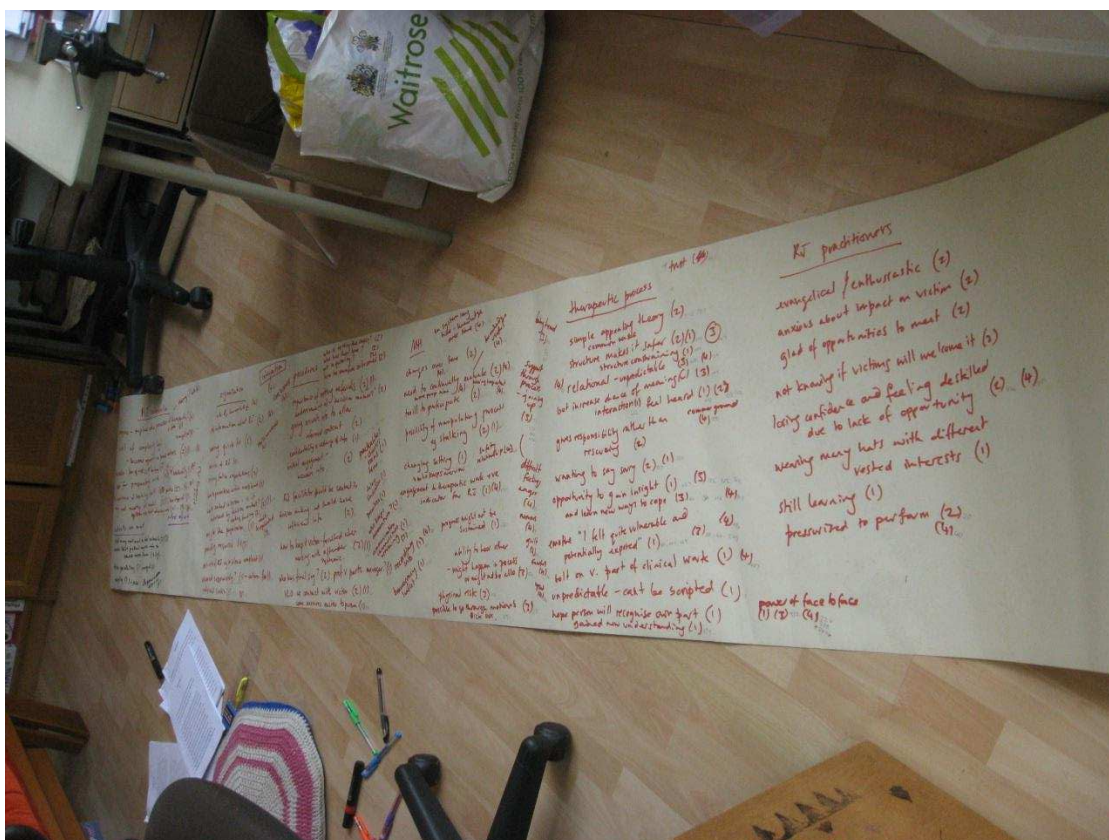
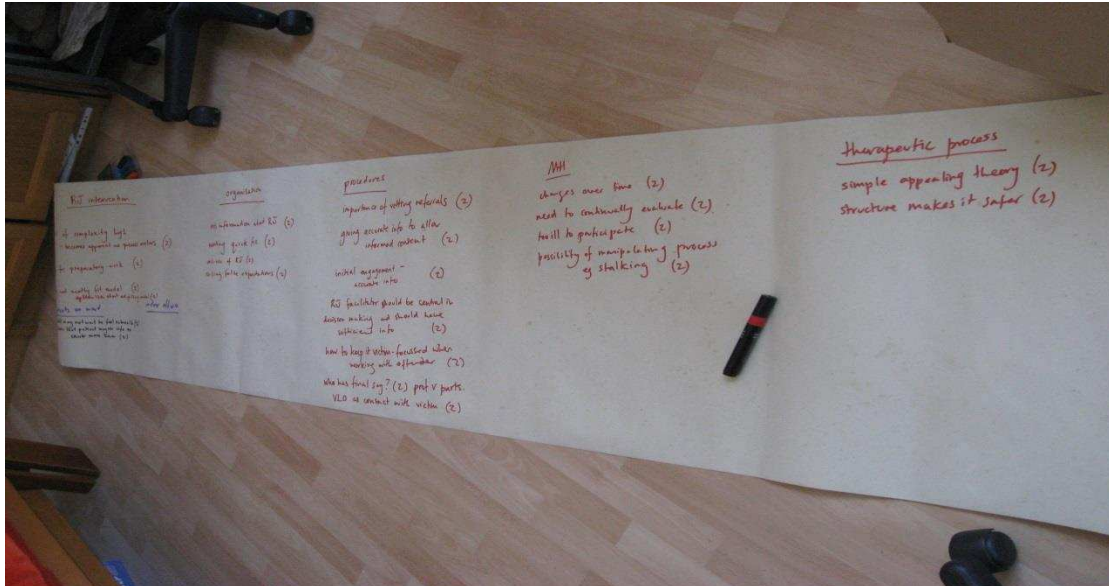
## **Appendix 9**

### **Transcribed and coded interview**

This has been removed from the electronic copy

# Appendix 10

## Development of focussed codes



**RJ intervention** - having if both (4)  
 purpose - replace other processes or therapeutic? (2)  
 level of complexity high (5) - becomes apparent as process evolves (2) (1) (3) (5) (7)  
 time scales: too quick (2) too long (1) (2) (3) (4) (5) (6) (7)  
 need for preparatory work (5) - neutrality (1) (4) (5) (7)  
 importance of training / skills (2) (3) practice (2) (3) (5) (7)  
 may not neatly fit model (2) (1) 'non-typical' (3) (4) (5) (7)  
 optimism about adjusting model (2) (3) (4) (5) (7)  
 incidents on ward quick response?  
 staff may not want to feel vulnerable (2) (1) (5)  
 concern that patient may use info to cause more harm (2) (3) (4) (5) (7)  
 offence paralleling (1) unequal (3)  
 naivety (1) - new allegiance in room (4)  
 VLO role: want to say sorry structured way to meet victim - not suffer on victim empathy. Shame. need to be seen as VLO.

**Integration**  
 medical model (6) (7)  
 organisation  
 lack of knowledge (4)  
 MIS information about RJ (2) (4)  
 wanting quick fix (2) (7)  
 mis-use of RJ (2)  
 raising false expectations (2)  
 how to prioritise within workload (2) (7)  
 how to embed in system - is it endorsed by decision makers? (2) (3) (5) (7)  
 may be the perpetrator (1) (3) (7)  
 providing resources (1) (3) (7)  
 mis-use of RJ as to silence complaint (1)  
 viewed suspiciously? (1) - culture.  
 external links (1) (3) (5) (7) VLO

**Integration**  
 knowledge (4)  
 about RJ (2) (4) (6) (7)  
 quick response?  
 importance of vetting referrals (2) (1) (7)  
 endorsement of 'decision makers' (2)  
 giving accurate info to allow informed consent (2)  
 confidentiality v. exchange of info (1)  
 initial engagement - accurate info (2)  
 RJ facilitator should be central in decision making and should have sufficient info (2)  
 how to keep it victim-focused when working with offender systemic. (2) (1)  
 who has final say? (2) prof v parts. manager? (1) recording info (1) (4) (7)  
 VLO as contact with victim (2) (1)  
 some avenues easier to pursue (1) (2) (3) (4) (5) (6) (7) VLO (6)

**core business procedures**  
 who is vetting the cases? (2)  
 who has the time? (2)  
 not a priority?  
 how to measure outcomes (2)  
 MH in system: changes over time, need to continual more prep time, to will to participate, possibility of many steps, changing setting, who keeps engagement in the indicators, who keeps momentum? (1) (5) (7)  
 delay - priorities - diaries rooms (1)  
 delay - prioritisation (1) (5) (7)  
 who keeps momentum? (1) (5) (7)  
 communication channels not working (5) (7) (10)  
 recording info (1) (4) (7)  
 transparency (1) (4) (7)



in system long  
 hide - knowledge  
 over time (4) 76, 193

MH  
 changes over time (2) 14, 191  
 need to continually evaluate (2) 14, 191  
 more prep time (4) 76  
 too ill to participate (2) 22, 9  
 possibility of manipulating process  
 of stalking (2) (1) 22, 9  
 changing setting (1)  
 who keeps overview  
 engagement in therapeutic work +ve  
 indicator for RJ (1) (4) 4, 10  
 (7) 31, 177  
 progress might not be  
 sustained (1) 632  
 ability to hear other  
 - might happen in process  
 or might not be able (3) 24  
 physical risk (3) 104  
 possible to go through motions  
 - tick box 231

knowledge  
 useful  
 (14) 238  
 (5) 64, 78  
 (2) 14, 191  
 (6) 274  
 (5) 31  
 (3) 71  
 (2) 278  
 (4) 299  
 (2) 246

baby heard (3) 49  
 support through process - joining up (3) 71  
 difficult feelings anger nervous (4) 31  
 guilt (4) 31  
 fears (4) 14  
 upset (4) 208  
 (3) 28

therapeutic process  
 simple appealing to common sense  
 (6) 22 structure makes it structure con  
 (4) 22 relational - unpredict  
 but increase chance of interaction (6) 22  
 gives responsibility rather rescuing (6) 22  
 wanting to say sorry  
 opportunity to gain insight and learn new ways (6) 22  
 emotive "I felt quite vulnerable and potentially exposed" (1) 22  
 bolt on v. part of (6) 22  
 unpredictable - can't be scripted (1) 22  
 hope person will recognise own part (1) 22  
 gained new understanding (1) 22

practicalities - diverts time (1)  
 delay frustration (1) (5) 2, 12  
 priorities (1)  
 who keeps momentum? (1)  
 communication channels not working (1) (5) 2, 12  
 recording (1) (1) 195  
 beanocracy (1) (1) 195

just (4) 141  
 (3) 18, 201, 209

therapeutic process  
 simple appealing theory (2) 210, 197 (7) 30 (3) 30  
 common sense  
 (6) 22 structure makes it safer (2) (1) (3) (5) 30  
 structure constraining (1) 30  
 (4) 22 relational - unpredictable (3) 210, (4) 208 (5) 30, 279, 197  
 but increase chance of meaningful interaction (1) (3) 197  
 interaction (1) feel heard (1) (2) 30  
 common ground (4) 31  
 gives responsibility rather than rescuing (2) (5) 30  
 wanting to say sorry (2) (1) 30  
 opportunity to gain insight (1) (5) (5) 30, 279, 197  
 (3) 210, (4) 208 (4) 31  
 emotive "I felt quite vulnerable and potentially exposed" (1) 30, 307, 448  
 (3) 210, (4) 208 (5) 30, 279, 197  
 bolt on v. part of clinical work (1) (4) 30  
 - (6) 22 = can't be scripted (1) 30  
 unpredictable - can't be scripted (1) 30  
 hope person will recognise own part (1) 30  
 gained new understanding (1) 30

RJ practitioners  
 evangelical / enthusiastic (2) (5) 30  
 anxious about impact on victim (2) (7) 30  
 glad of opportunities to meet (2)  
 not knowing if victims will welcome it (2)  
 losing confidence and feeling deskilled due to lack of opportunity (2) (4) 30  
 wearing many hats with different vested interests (1)  
 still learning (1)  
 pressurized to perform (2) 30  
 sustain optimism (7) 30  
 power of face to face (1) (3) 30 (4) 30

## Appendix 11

### Theoretical codes

#### Experience of Restorative Approaches

Theoretical code	Focussed code	Quote	Participant
<b>Powerful and positively transformative (T1)</b>	<b><i>Containment for emotional encounter.</i></b>	... they wanted to wait for this opportunity to say their piece to get it off their chest, in a structured way, in the presence of another independent person who was going to be able to validate and hear that as well, and contained.	Participant 1 RJ facilitator 393-396
		I think it's something that a lot of the time you wish you'd do anyway, and it just puts the structure around that, because sometimes you know, you hear about these sort of arguments or disagreements, or things that have happened on the ward, and you just want to say: 'Right, you come here, you come here, sit down, let's talk about this' but it puts a more formal structure around that, it allows you to do it in a way that's more helpful rather than coming across like someone's slightly scary mum.	Participant 2 RJ facilitator 318-325
		... you sort of talk about the issue and look at a resolution, it takes you on a whole journey, but sign-posted all the way, so it's not like, .... you're on this emotional journey and you don't know where it's going to go and it's like, ....you feel like you're rattling round and feel unsafe. Felt absolutely safe the whole way and that, that was a big thing for me is the sort of feeling safe.  I felt very safe and I felt it was very contained and controlled. And if there had been any chink at all, it's so easy to sort of fall through or that's how it felt, feeling really fragile. But the good thing about it as well, was he, at the end of each session, when he did a summary, it was almost like he kind of unpacked this Pandora's box and by the end it was just quite neatly packed again, until the next time it started.	Participant 3 Victim 147-152  252-256
		... so I played it exactly according to the structures that need to be in place. And because I did that, I think we got to a better outcome, because no-one interrupted the other, or when they did, I stopped them. And they did on occasions, and I stopped them. And they had to listen, and to painful truths I	Participant 5 RJ facilitator 429-435

		think on occasions, be able to reflect on it in a calm way, and come out of it certainly not feeling worse, but I think empowered from it to be able to move on.	
		So I think, for me, it provides... it's a kind of structured way of managing that, that it isn't actually... I guess for me, if it's done well, it produces a kind of judgment on people which isn't about actually, you know, identifying people as having being wrong or bad or... you know, it's just that kind of being able to work with something where there's so much emotion in a way that manages that and feels fair. I think that is so difficult to do, I guess... you know, some facilitators become more experienced, they would hopefully get to a place where they could manage it in that way, and I think just that's what interests me, the possibility of a process that is kind of holding that all together through... essentially through structure and allowing people to actually be able to speak.	Participant 6 RJ facilitator 432-442
		Just because you ....., it's....., there's something always to be gained, there are two sides, even supposedly opposing sides, come together and discuss it openly in a safe environment. I think that could be very healing, I think it can be very useful.	Participant 8 Patient 394-397
		And her sort of history is that afterwards she sort of said, "Sorry", but then she still assaults staff and so I didn't really want it to be just we come in, have a chat, just the two of us, she says, "Sorry" and then continues to do it. I wanted it done in a more kind of structured and therapeutic way.  I was quite happy with the structure.	Participant 9 Victim 10-14  60
	<b>Immediacy</b>	And the extent to which you're always talking about something that is other or out there means that there's a distancing, and I think that bringing another person into the room has the potential to be worth a thousand therapy sessions, because of all the emotional power of the experience, and that could either be the victim of the actual offence, or a representative of the victim of the offence, but the possibility of the service user hearing and the patient offender hearing from someone who was actually involved and implicated, and not hearing about the harm that they may have caused from a staff member, it's kind of in a way your patients might tell you: 'Well you're paid to say that. You would say that. You're over-playing it or it wasn't as bad as all that' that having the opportunity to hear actually maybe it was as bad as that or, in fact, it might have been	Participant 1 RJ facilitator 664-678

		worse than that, is potentially going to make a big difference to our rehabilitation and promotion of the recovery of offender patients or forensic service users.	
		...and suddenly they're faced with this person. It could be a family member... and I think it's actually useful in sort of working through the process with somebody in the room, ..... particularly somebody who've minimised their offences and said, "Well I only did this. Well they didn't die did they?" You trying to say, "Well actually ...." I can sit there all day long with somebody and they're still not going to get the impact of their behaviours, therefore their self management of their mental health isn't going to be as good as maybe somebody who does kind of get the impact of what they did and if they become unwell they behave in this way.	Participant 3 RJ facilitator 348-355
		but to actually face the impact of what they did and to have that opportunity to just sit with  I do a lot of work with sex offenders and in particular the kind of role plays that I've just been talking about, and I think that's when I've seen more genuine expressions of remorse and kind of realization of acceptance of what they've done. And I think to have the opportunity for some people to actually meet with their victim and face the kind of fears...	Participant 4 RJ facilitator 348-352  388-393
		And you know it's a difficult thing to do as a professional with a patient, as well, because you, you know, you're not just being a professional, you're being a bit more human and you're being bit ....., it did affect me, you don't know whether she's sitting there thinking, "Ooo what a wimp", you know, "Well she's an easy target now", you know, that worried me a lot throughout. But ultimately, when I came out of the meeting, even though I said to the psychologist that it was a bit of a disappointment, I did feel like I'd got it off my chest and I'd been able to say what I wanted to say in a correct way. And it was definitely a good forum for that and I know other nurses who have been hit by her said they wished they'd done what I'd done.  A bit like I'd bared my soul...	Participant 9 Victim 107-106  233
		Q: what was it like listening to her? A: Upsetting. Q: Yes. Do you remember, ..... does anything stand out for you? Q: Um, when she went home and she had to tell her nephew or something, why she had marks on her face. Q: How did that affect you? A: Quite a lot.	Participant 10 Patient 33-51

		<p>Q: Yes. In what way did that affect you, hearing that?</p> <p>A: I don't know really.</p> <p>Q: It's hard to hear that?</p> <p>A: Yes.</p>	
	<b><i>New understanding and changed functioning</i></b>	<p>So that was powerful, that was moving, and I felt a great deal about my role in that, and I wishes to have done things better, appreciated things better</p> <p>It felt as if there was a processing that had happened that had definitely moved that service user on. Whether it had got to the point that I'd hoped in terms of taking the next step towards thinking about how might this link to the offence I'm not sure about that, but if it seemed that that person's capacity to recognize her impact on another person and the way in which she comes across and how intimidating she may be in ways that she didn't appreciate, I think was beneficial.</p> <p>... so that there's an emotional immediacy to the experience and I believe that therapeutically that is mutative or transformative, and promotes growth and development, and emotional insight, and ultimately behaviour change</p>	<p>Participant 1 RJ facilitator 387-388</p> <p>625-631</p> <p>661-664</p>
		<p>So that gave a bit more perspective on it rather than sort of feel ....., I felt less helpless at that point, because I saw it more as a series of events, and I felt less of a victim. And then it sort of progressed to the emotional side of it and he brought out things that I hadn't kind of thought about. It wasn't isolated, it was sort of the whole event and the whole...</p>	<p>Participant 3 Victim 64-68</p>
		<p>And I think that that did eventually happen, cause they are now, as I say, working on the unit together, so there's been no further incidents or allegations.</p> <p>Whereas I think if he could have actually heard what it felt like to be on the receiving end of that allegation, that would have possibly made him think differently. And also, it would have been helpful for them both to see that they actually both had the same emotions about the same... you know, that's what joining them together was that they both were very angry.</p> <p>I think it would have maybe helped them to think, I certainly think it would have made the patient think differently, and sometimes to recognize that actually the member of staff is a human and has a life, and has things going on outside of the ward environment. I also</p>	<p>Participant 4 RJ Facilitator 241-243</p> <p>327-332</p> <p>348-352</p>

		<p>think it would have helped the member of staff to hear that the patient was sorry</p> <p>I think it makes it much more real than kind of, I guess, even when I think about therapies that I've done, sometimes I've done role play where I actually invite almost the person to get in the role of the other person and to almost talk about themselves as the other person. And I always think that's a much more powerful connection to the feeling than it is if you're just sitting and talking it through with someone. So for me, to actually have the parties in the room, where they can actually, obviously they're themselves, being themselves but expressing that emotion I think is important. And I think would have had a huge impact on both of them</p> <p>And I think to have the opportunity for some people to actually meet with their victim and face the kind of fears, and you know even for some, I'm thinking about some offenders that I know that kind of spend the rest of their time thinking: 'Gosh, this is what I did to my victim!' and almost traumatized by the impact on the victim and thinking: 'Their life is ruined and I've been responsible for that, and I've destroyed someone's life'. I think if they could put the reality principle back into that, and actually meet with their victim, and yes they will, there are severe consequences for the victim and the impact that they need to hear, but at the same time I think it would be important for them to actually..., for the victim to see that the offender can move on, rather than having a vision of them as being this person that has done what they've done. But at the same time, for the offender, I'm thinking part of their recovery, it's important for them to, not be forgiven, I think cause that's more about their needs than the victim's, but to actually face the impact of what they did and to have that opportunity to just sit with, I think and shift their own thinking and their own awareness about, kind of act as a deterrent for them doing, you know a similar thing again. I think it's a very powerful measure.</p> <p>*** showed us a clip of a woman that had been raped and got involved, and I just thought. I know it may not be for everyone and maybe not for that type of offense, but I thought how powerful that was that she actually met with the offender. And I thought for her own recovery as well, I think it was a helpful move because otherwise I think victims can stay stuck in the trauma of what happened and that's it, they don't, know, they</p>	<p>366-374</p> <p>391-408</p> <p>428-434</p>
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		just see the image of this male or whoever it was.	
		I think they both came out with they knew what should happen and who was at fault, and what the outcome must be. And by the time we'd finished, I think they reflected differently on it and began to reflect on their own behaviours more than they'd ever done before.	Participant 5 RJ facilitator 300-303
		Despite his mental state he was able to hear what we were saying, he apologised for his behaviour; initially he tried to write it off as a joke, but then later he accepted that it had come off badly and it had made the occupational therapist very uncomfortable.  He was able to take on board in a way that I'd half expected him not to be able to do, given his history of denial.	Participant 7 RJ facilitator 30-33  65-67
		I think that would be very useful for me, both in terms of finding .....um....., having a better understanding of my discharge, also in terms of future discharges. Because I want to have, ..... when I am discharged again I want to have a very good relationship, you know, with my CPN, my social worker, my consultant.	Participant 8 Patient 409-412
		So I didn't have to, sort of, fear being ....., the fear of being assaulted kind of went away after the meeting quite quickly, which I was really surprised at. And also she did approach me and said, "That's it. No more assaults". And I thought, "O.K., you've never said that before."  I think if we hadn't had that meeting it would have changed our relationship. I would have been very, yes, no here are your needs met. But that would have been it. I wouldn't have been able to interact any more than that with her. But I think because we've had that meeting she did, she did sort of come up to me a couple of times afterwards and say, "Look, you know I am really sorry," and, you know, "Is that it now can we leave it?" And I said, "Yes, that's it, that's what I wanted to do, I wanted to have that and leave it behind in that meeting and move on." And I made that quite clear in the meeting as well, which we both kind of have done. Tentatively a bit, but yes, it's worked well, really well.  And I got to kind, you know, go for it really and as well I think, sort of, when I did, as I say, when I did tell her about how it affected me away from work, seeing the bit of eye	Participant 9 Victim 174-178  180-189  256-260

		<p>contact there about, that acknowledgement from her that yes she was listening to me and actually, you know, there was a bit of compassion there. I think that went well.</p> <p>The only surprising thing, she mentioned something about it being a bit like sort of round the family and getting physically violent with your family, which I thought is actually maybe a truer reason as to why she would hit a member of staff. Because she gets very close to them and then she almost pushes them away. The psychologist sort of said to me, "It's a bit like domestic violence, the relationship you're in." And once I was given that comparison as well, I thought, "Yes, that ....." So that made a bit ....., so there was a bit more sense made out of why she'd hit me, because I really wasn't buying the whole "you're a demon, because you're wearing a red T-shirt" kind of story.</p>	286-295
		<p>...it just made me realise that peoples got families to go back to.</p> <p>It cleared the air a bit, so it was a bit easier to talk to her.</p> <p>I've been more thoughtful about things...</p> <p>I didn't assault anyone... I didn't want to do it again...</p>	<p>Participant 10 Patient 60 138</p> <p>148</p> <p>168</p>



<p><b>Instinctually and intellectually appealing (T2)</b></p>	<p><b><i>Fits with personal ethics and beliefs</i></b></p>	<p>And that was I suppose the simplest starting point where we thought that we have a simple model of an aggrieved party and a party who has caused offence, and that there would be a way of trying to resolve that.</p> <p>But also I think that there is the possibility that our focus on having only care for and regard for the perpetrator, the offending patient, if we introduce restorative justice we can also attend to the victim and that our duty of care in a way can extend beyond just the patient, and that creates the possibility for a systemic intervention that's wider. It's also creating a possibility for a sense a societal intervention in that we would be promoting the social reintegration of both the offender patient and the victim, because the extent to which the victim still feels traumatized and alienated from society or at risk, can be attended to but also the patient themselves could have the experience of acceptance and rapprochement of being accepted back into the fold.</p>	<p>Participant 1 RJ Facilitator 96-99</p> <p>680-689</p>
		<p>I think part of it is ridiculously straightforward, in that actually we know I think the best way to sort out any problem is to get everyone involved in the room and sit down and talk about it, in a sensible manner which means that everyone knows what's going on with everyone else and you can try and sort of bash out a solution, and I think that that very much appeals to me... because actually, let's just keep it as simple as possible, this is a very skilled but very straightforward way of dealing with it... I think it goes very much back to almost people's childhood, doesn't it? You come here, you hurt them, you say sorry. You know, and it almost brings it down to that very simple level, but with adults and with adults that need the opportunity to be heard and have the opportunity to express what happens and why it happened, and what was or wasn't their intent, and I think that it's sort of taking that very simple 'Say you're sorry. You accept that apology. Shake hands. Now you're friends and go and play.' It takes that to a sort of grown-up level where it puts back responsibility more to the individuals which I think is something that is quite often lacking in mental health services.</p>	<p>Participant 2 RJ Facilitator 309-338</p>
		<p>Yes, it makes sense to me because it's not the people in the know telling the people not in the know. It's helping the people not in the know to know a bit more from their viewpoint, and then come to a solution which will work for them, and quite often it wouldn't be my solution which would work for them. When it's appropriate it's theirs. And most times, they choose something which surprises</p>	<p>Participant 5 RJ facilitator 597-605</p>

		<p>themselves as well, and most people come up with some really good ideas for moving forward, and because they're actually committing, and it's their ideas they want to happen, it helps them move forward. And I think it's a very respectful process.</p>	
		<p>I guess for me, if it's done well, it produces a kind of judgment on people which isn't about actually, you know, identifying people as having being wrong or bad or... you know, it's just that kind of being able to work with something where there's so much emotion in a way that manages that and feels fair.</p>	<p>Participant 6 RJ facilitator 433-437</p>
		<p>... restorative justice is a ..., it has a sort of very basic appeal in some ways and I don't think it's a difficult thing to set up or to ..... or for staff to connect with...</p> <p>it asks people to take responsibility for their actions, to think about how things are going to be, how they're going to be different in future. How they're going to respond differently in the future. Overall it has a much more sophisticated, mature feel to it than a more punitive</p>	<p>Participant 7 RJ facilitator 80-81</p> <p>216-219</p>
		<p>I think a lot can be gained on both sides through, you know, open discussion and I think, you know, especially by the nature of the restorative justice process that it, you know, considers all angles about how everyone has been affected. I think that's the best way to unders....., gain better understanding for both myself and the community team, of the situation.</p> <p>So it seemed a brilliant idea, that idea of taking both parties as being affected by whatever event that brought them to it, to the process .....um..... and both sides could actually learn something, which is of value to both of them, through it. You know, from having that more .....um..... open, more impartial view. You know, taking .... you know, .....um..... for the second person as well as the first. I thought that, that sounds a brilliant idea.</p>	<p>Participant 8 Patient 137-141</p> <p>244-249</p>
	<p><b><i>Fits with therapeutic goals</i></b></p>	<p>And in that way, without wanting to be patronizing, the possibility that the service user may gain insight through this process and therefore perhaps be in a better position, given that we had the clinical views that there was the possibility that there was offence-paralleling behaviour involved, and we wanted to try and help the service user to understand the early markers of their own risk, when they had started to become aggrieved.</p> <p>It feels to me that restorative processes being</p>	<p>Participant 1 RJ facilitator 122-127</p> <p>703-709</p>

		<p>embedded in the organization create the opportunity for a re-iteration or a re-emergence of the principles of therapeutic community, but perhaps without all of the constraints and the trappings and the requirements that brings with it, so in a way a slice of what we know works from TCs could be reintroduced into the organization in a way that is contemporary and also acceptable to the organization</p>	
		<p>It takes that to a sort of grown-up level where it puts back responsibility more to the individuals which I think is something that is quite often lacking in mental health services. I think sometimes people get rescued too much and get excused a bit too much, and I think it puts back some of that responsibility, and actually the ability to take responsibility for people that do get fed up of being rescued too much</p>	<p>Participant 2 RJ facilitator 336-341</p>
		<p>I can sit there all day long with somebody and they're still not going to get the impact of their behaviours, therefore their self-management of their mental health isn't going to be as good as maybe somebody who does kind of get the impact of what they did and if they become unwell they behave in this way.</p>	<p>Participant 3 Victim 351-355</p>
		<p>And I guess I've been working in Forensics for 14 years and I do quite a lot of victim empathy work, and in that, I do a lot of work with sex offenders and in particular the kind of role plays that I've just been talking about, and I think that's when I've seen more genuine expressions of remorse and kind of realization of acceptance of what they've done. And I think to have the opportunity for some people to actually meet with their victim and face the kind of fears, and you know even for some, I'm thinking about some offenders that I know that kind of spend the rest of their time thinking: 'Gosh, this is what I did to my victim!' and almost traumatized by the impact on the victim and thinking: 'Their life is ruined and I've been responsible for that, and I've destroyed someone's life'. I think if they could put the reality principle back into that, and actually meet with their victim, and yes they will, there are severe consequences for the victim and the impact that they need to hear, but at the same time I think it would be important for them to actually... for the victim to see that the offender can move on, rather than having a vision of them as being this person that has done what they've done. But at the same time, for the offender, I'm thinking part of their recovery, it's important for them to, not be forgiven, I think cause that's more about their needs than the victim's, but to actually face</p>	<p>Participant 4 RJ facilitator 386-408</p>

		the impact of what they did and to have that opportunity to just sit with, I think and shift their own thinking and their own awareness about, kind of act as a deterrent for them doing, you know a similar thing again. I think it's a very powerful measure.	
		... had to carefully explain to both parties the purpose of the restorative intervention. That it was something that it was part of the establishment's move towards a recovery program, and then it was essential, it could be valuable for both of them to undertake this with me.	Participant 5 RJ facilitator 134-138
		... in terms of looking at offence-related factors, I think it would have helped the staff team to be clear about how they were formulating things.  ... but it's such an important part of someone's recovery basically, that, you know, they're able to reflect on what has happened and their kind of responsibility, and I think it's a critical part of relapse prevention.	Participant 6 RJ facilitator 162-164  287-290
		It fitted with what I suppose I was trying to work with, one was recognising the harmful behaviours that he'd engaged in, as part of an assessment process, so it fitted with that.  It feels like a more mature approach to working with clients, you know. Certainly it fits with a recovery ethos, the idea of working alongside somebody to figure something out, rather than ....., doing that together rather than ..... taking, forming a judgement, taking a view and then acting accordingly, I think there's a, I didn't come in to... I suppose there's a hesitance of anybody working therapeutically in forensic services to not be too allied with a punitive, because, you know, kind of criminal justice approach to offending. For different reasons it's right in my head to have a clear blue water between a security role and a therapeutic role. I think RJ offers a more therapeutic approach to addressing problematic behaviours.  The other thing I like about it, it can moderate a really unhelpful dynamic on the ward, where the tendency is to retaliate with punitive action and I think it ....., you know, if you've got RJ in the mix as well it means that people have to think about having conversations about what happened rather than just jumping to a conclusion and putting something very punitive in place. So I think, you know, it has a moderating effect on a dynamic that's always around in patient services. That kind of temptation to use rules	Participant 7 RJ facilitator 153-155  193-201  206-216

		as a way of retaliating against the sort of behavioural difficulties, you know, something that often comes up in reflective practice. So that appeals to me. I mean I think it does fit with the therapeutic ethos , it doesn't...., it creates the space to talk about things that are difficult... that can't be ...., that's exactly what we're there to do half of the,..... most of the time.	
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<b>Generates 'converts' (T3)</b>	<b>Conviction about efficacy</b>	<p>I think that I have a strong conviction that the being able to bring the offender and victim together into an encounter, into a meeting, into an exchange in which there's real communication, has the possibility of being profoundly therapeutic for both parties</p> <p>So it's going to be very tricky, very challenging, but I still very strongly believe worth doing.</p>	<p>Participant 1 RJ facilitator 654-657</p> <p>726-728</p>
		<p>I do think that it's got a relevance, and it needs to be used because it's beneficial, and I think that the actual establishment gains from it.</p>	<p>Participant 5 RJ facilitator 659-661</p>
		<p>I guess we've got all kinds of extreme personalities here, so I think it's just more complicated but I think there definitely is a place for it here.</p>	<p>Participant 6 RJ facilitator 278-280</p>
		<p>And I get the very strong sense that there are people who could have benefitted from this approach, just think ....., you know, perhaps people who've been with the service for two, three years, done a lot of work, are ready to think about their offending in a different way, their victims in a different way. You know, I've worked with people who could do that work regardless of their offending ....., you know the seriousness of their offending history and regardless of their mental illness as well, or personality difficulties</p>	<p>Participant 7 RJ facilitator 280-286</p>
		<p>I think it should be done, I think, certainly on the ward, after an inci ....., when you've been assaulted by, you know, a patient, particularly in that situation it should, it should be used.</p>	<p>Participant 9 Victim 319-321</p>
		<p>I don't think it should be all the time, because some are like little assaults and like pushing someone and that. But when it's a big incident, yes, it should be.</p>	<p>Participant 10 Patient 247-249</p>
	<b>Endorsement</b>	<p>As regards the process itself, I would absolutely recommend it to anybody...</p> <p>Yes, absolutely, I'd recommend it to anybody</p> <p>But yes, because as well I haven't had an opportunity of really feeding back and saying how useful it is. And anything that I might be able to do, that would help to promote it in the service, I am more than willing to do. I do think it is something we should be adopting and should be focussing on</p>	<p>Participant 3 Victim 131-132 260</p> <p>368-371</p>
		<p>I think it would have been a fantastic experience to actually, to be part of, if we could have got them together</p> <p>I hope it becomes something that we do as our core business really</p>	<p>Participant 4 RJ facilitator 317-318</p> <p>478-479</p>

		<p>... and I've seen with some people I've worked with, it's made such a significant difference to the way they viewed themselves and could move on, as against get trapped where they were</p> <p>I'm so thrilled that people want to move RJ on here</p>	<p>Participant 5 RJ facilitator 583-585</p> <p>618-619</p>
		I think there's a really great value in it, and particularly if it's done in a structured way	Participant 6 RJ facilitator 297-298
		I think it should almost be sort of written in the policy that that's what, you know, happens after an assault	Participant 9 Victim 350-351

## Factors Particular to the Setting

<p><b>Ability of facilitators to manage complexity with high level of skill (T4)</b></p>	<p><b>Highly emotive situations</b></p>	<p>The staff member was very emotional and it became clear that, from the feedback from the facilitator to me, it was that actually that this was more complicated than might meet the eye.</p> <p>There were definitely things that emerged that were much deeper, much more painful than I'd appreciated, much more personal.</p>	<p>Participant 1 RJ facilitator 230-233</p> <p>380-382</p>
		<p>... it turned out they had a lot of personal issues going on at that time which he just fed into this whole situation which is incredibly complex and difficult.</p> <p>... has had no contact with his children since that time I think 20 years ago, has now expressed an interest in wanting to contact them, and I think the discussion that's been had is very much around: 'Is that helpful and who is it helpful for? How do we go about that? Are they in contact with VLOs? And how do we manage that? And is RJ something that could be looked at because one thing that he's brought is 'I've never said sorry'. So that's something that his team will have a think about, whether it could be appropriate to use, and obviously how we then make the approaches to the family to have those discussions 20 years down the line...</p>	<p>Participant 2 RJ facilitator 98-100</p> <p>370-378</p>
		<p>... up until then I'd been thinking it through in a very emotional way and it was really impacting on my work.</p> <p>I'd read so much on it, but never actually seen it in action, but to personally experience it and it ....., what it ....., kind of what impressed me was the skill in the, ..... doing the absolute factual bit and taking the emotion out of it. And then doing the controlled emotion, but still coming away feeling that you've been listened to. I would describe it almost like thinking out loud, you're able to put things more in perspective</p> <p>we work with people who've committed sort of GBH and above, some pretty awful offences and a lot of the time, at least somewhere down the line (we) get people say how bad they feel about what they've done. For some, RJ won't work because there are exclusion zones, there's non-contact conditions and so they'll never be able to meet the victim, but it ..... for some, it could be at some point they'll bump into them and there's been nothing and suddenly</p>	<p>Participant 3 Victim 50-51</p> <p>132-136</p> <p>343-350</p>



		they're faced with this person. It could be a family member... and I think it's actually useful in sort of working through the process with somebody.	
		... because the member of staff was quite angry about the allegation, and the impact it had had on him having to not be at work and that side of things, and the patient was quite nervous about that member of staff returning back to same unit in the same ward.  ... I think just struck me how actually emotive that was, and how angry he was. I guess, you know, obviously it's a little different when we were doing the role plays and things like that, but something about the realness of how strong and how powerful the feeling is that's in the room, and so I guess I was kind of aware of being sensitive around that and how to kind of handle what also appeared to be quite confidential information about his personal life, so it was kind of sort of thinking of all of those dynamics I think.	Participant 4 RJ facilitator 29-32  287-293
		It actually needed to go on as long as it did which is 1 ½ hours, an intense meeting, very emotional, lots of tears shed, and it changed my perception of the whole program, of the whole issue.  ... so they both came in, both felt victimized, humiliated, frustrated, hurt, bruised.	Participant 5 RJ facilitator 148-150  567-568
		... even though I've known this patient for a long time, it was quite nerve wracking  ....., it did get a bit emotional at some points, whereas I hadn't shown, I hadn't cried, I hadn't shown anything like that, I'd been a bit angry, but I hadn't, that side of me I hadn't, but in that meeting, for me it felt very difficult  Because I was angry....., it affected me, it affected me on my days off, you know, it affected my relationships with my family and it questioned me about my job and whether I should be there, all that kind of thing. And I thought, "No, the only way I'm going to be able to....., is to be able to tell her all this." Because I can't continue working with her professionally and really close at a therapeutic level unless I tell her the truth.	Participant 9 Victim 65-66 76-79  142-147
		Nervous... That she wouldn't forgive me.  Upsetting.	Participant 10 Patient 22-26  35
	<b>Neutrality in the context of working relationships</b>	... and that in a way my having adopted a neutral approach or possibly an approach that wasn't actually neutral because it was 'What do we need to try and understand	Participant 1 RJ facilitator 146-152

		<p>about the patient's experience in this?', that by focusing on the patient's experience the staff member felt that their victimization had been lost, that they'd been left out of this and that it had all been about the vulnerable patient and not a recognition about the vulnerable staff member</p> <p>I think that we assumed that having a staff team who were trained in facilitation of restorative justice meant we were resourced. But actually there were aspects of this that required not simply a skill set, but a neutrality of position.</p>	<p>200-203</p>
		<p>... what the slight anxiety is will the victim view us as being on the side of the perpetrator, because they're our clients, they're the individuals we're working with. You know, will they potentially view as somehow affiliated with this individual and you explain who you are, where you work and what your role is on a day to day basis, will that be a negative? You know, should we be dealing with that person?</p> <p>You can imagine a conference whereby a client that you know really well and you've been working with for years: 'Well I didn't mean to do that, did I? Did I? You can tell, I've spoken to you about it, you know'. However well prepared things are, you can still end up with a very difficult, you know, situation and the victim feeling more: 'Well, why did you get me here, if you're not given a listen to what I was going to say?' I think that could be a really tricky situation, one that would need a lot of careful thought and management</p>	<p>Participant 2 RJ facilitator 415-420</p> <p>425-431</p>
		<p>I do think neutrality is important, absolutely 100% cause I think it could be, if you were slightly emotive about, or you witnessed the incident or something like that, I think I would decline holding a conference at that point, if I equally had sort of feeling about it. But I think when I talk about the kind of relationship that I have with that client, what I think it allowed me to see was that if I had had more time, cause I had back in 2007 worked in a therapeutic way with him, and I guess for me I'm kind of mindful of his own interpersonal style and I do think that if he'd been able to contain his anxiety better, that actually it would have had an outcome where he would have stayed in the room. So I think that insight was helpful to have, and probably if I'd had the time I would have tried to pursue it slightly longer with him, trying to just work with his anxiety. I also think that in some ways, having a relationship of some sort enables the individual to have some</p>	<p>Participant 4 RJ facilitator 127-143</p>

		<p>kind of safety measure as well, that if they have a rapport with you and they feel contained by you, that could work as well. But I think about the actual incident it's important to remain obviously neutral about that, and not to be seen to be siding with one or the other.</p> <p>... certainly for example if I was currently engaged with someone in a therapeutic way now, I wouldn't then mediate a restorative conference with them. Because it just would feel an inappropriate thing to do, whereas it'd felt different with this particular individual because it had been quite a few years ago, and our relationship was over in terms of anything that we were doing working together.</p> <p>I'd think that they might feel that if I was remaining in a neutral stance in the conference, that that possibly could impact on them as me being rejecting to them, or not understanding them, knowing the context of certain aspects about their background, or things that we might talk about in therapy, and I think this sort of differences that might come up, it could feel rejecting for them</p>	<p>166-172</p> <p>181-186</p>
		<p>Neutrality is important. That I had nothing to lose or gain by what was occurring. So I wasn't looking to either defend or attack the system, or defend or attack the nurse, or defend or attack the patient, I came in and asked what actually happened and found out and about the feelings and emotions that the incident, and then how we could work with that. So I think that if it was with two people that were involved, I think that one of the people that have trained up could have run that, but not one who's working with those two all the time, because then they'll feel inhibited.</p>	<p>Participant 5 RJ facilitator 646-653</p>
		<p>Certainly in terms of assessing somebody for readiness it's very helpful to have prior knowledge of the person, and..... I think in any institutional intervention, if we used RJ at a routine level in the institution it would be impossible not to have some knowledge. It's likely that the facilitators involved would, at the very least, have a rudimentary knowledge of the people involved, really, even if you're not working them. Sixty five beds in two institutions on the site, you're likely to know something about the patients, from a practical level it would actually be more of a headache trying to find somebody who didn't know something about the patient. But, then there is the issue about</p>	<p>Participant 7 RJ facilitator 175-184</p>

		being directly involved in work with them and I can see the benefits of not having that, ... that kind of connection.	
	<b>Adaptability</b>	<p>So coming to what I was involved in, in a way it was a non-typical restorative justice event in a way, because it wasn't that we particularly got to an offender-victim conference, but rather that we were engaged in an organizational restorative process that hadn't many different parts to it, and didn't necessarily end up in having a what might be considered conventional RJ conference.</p> <p>I think that what emerged was that actually it was impossible to define who was the victim and who was the perpetrator, because it was complex. And that actually, it was only as the narrative unfolded that it became possible to see where offence and where hurt lay</p>	<p>Participant 1 RJ facilitator 49-54</p> <p>331-334</p>
		<p>And I think that's something that I sort of looking at it as using it as a model potentially without the scenarios is very much finding situations where both parties view themselves as victims, and how do you then work with that?</p> <p>... I think if you had a proper prolonged period of preparation where possibly you had consent from both parties to take information back and forward to be able to do that preparation work prior to any conference, then that could be possible</p>	<p>Participant 2 RJ facilitator 71-73</p> <p>185-188</p>
		But I would hate, .... what I would hate to see is, because my experience of it has been so positive, I would hate to see that it's, "Oh, this is great and this is new trendy .....", you know, one size fits all and then people say, "This is rubbish." It's not, if it's used properly and with the right people, it's not rubbish.	Participant 3 RJ facilitator 381-384
		And actually, he felt.. the feedback we got from him was very very positive. He actually said: 'You know, I'm sorry cause I've been so angry' and he was really quite upset, and that was coming through I think in, you know, some of what he was saying and then I think afterwards he kind of caught himself and just said 'Sorry, I'm not having a go at you, I'm just so frustrated'. So I think for him in the long run it was certainly quite a positive outcome, because what we did say was we even tried to get to the point where we could say to both parties: 'Look, this is what they're saying, this is what you're saying'. So we did manage to share that with both of them.	Participant 4 RJ facilitator 219-228

		I think it's important also to think about the different levels of RJ as well, it doesn't have to be a conference or mediation, that you could be writing a no-send letter or it could be writing a letter if the other party is willing to receive the letter. But thinking about kind of I guess what's helpful for, you know, individuals, cause I would imagine some, again I haven't had this experience, but I would imagine some clients being anxious about: 'Oh I don't know what to say' or 'I don't know how I would communicate that' or... so I guess sort of preparing around that, or even maybe as part of the preparation stage, there might be the need to have some sort of role play with that individual to think about what would it look like, or what might you say? So that they can prepare themselves for the day as well, things like that.	496-507
		And it actually took a slightly different route to what we intended, which was why I left it very open from the beginning.	Participant 5 RJ facilitator 141-143
		I thought this would be a good opportunity to kind of respond quickly to what he had done and to make sure that it was clear that the, .... that his actions hadn't been appropriate, that we wanted him to be able to reflect on that and, you know, literally within the hour rather than it being presented to him during a ward round, some weeks in advance or something.	Participant 7 RJ facilitator 12-16
	<b>Assessing ability to meaningfully engage</b>	Oh yes, it's important to say that in this whole process, things had snowballed for the service user who was at that time in the community, and they'd been recalled. And so they were re-admitted to conditions of medium security under a formal recall under the mental health act. And they were not very emotionally stable. And so from a clinical point of view, it became highly questionable as to whether or not this was the right time to be proceeding or to be putting the person under new pressure	Participant 1 RJ facilitator 258-265
		I think that there will be times when people are just too unwell with psychosis or just too caught up with aspects related to personality traits, that are going to make it too difficult for them to be able to engage meaningfully in the process. But I think it's something we should be considering all the time.	Participant 2 RJ facilitator 228-232
		I guess experience, intuition it can, ....tells you that someone just going through the motions as a, you know, "Aren't I good, I ticked another box, .... in things I need to do". So we do Victim Empathy programme	Participant 3 Victim 227-231

		here and again it's the same thing, how do you know if somebody's just going through the various levels without, ..... just, .....their get out of gaol quick card	
		Obviously there are limitations with certain individuals in our Trust as well, thinking about the mental health component, and how stable someone is and able to engage  I guess just thinking about kind of how stable and how well someone is, I would like to, again thinking about any kind of engagement where I'm asking someone to engage in an intervention, I would be looking for stability in terms of their kind of mental state, kind of medication, all sorts of things, their ability to consent and agree. I think that's the bit that I would say does with mental health, I think it's important to have the time and the space to do that and allow somebody to maybe be ambivalent and fluctuate	Participant 4 Victim 480-482  489-495
		And I didn't need to know any depth of knowledge about why that patient had come into the hospital in the first place. Just wanted to know present state of mind since she'd been released out into the community. So, that preparation was very important and gave me some thought about whether I could work with that patient.  But I did need to know about her stability and about her ability to operate in discussion-type process, or whether it could actually go to facilitation.	Participant 5 RJ facilitator 63-68  78-80
		And I think that happens quite a lot here, where you know, it might look like someone is actually at a point where they might be able to do quite focused preparatory work but then things might change and they're just not there anymore, and then by the time you go back to it, it can have a feel of, it's almost like you're dragging something up again... it's been around... and then it can kind of move on in a kind of chronic way. I think that can be quite a difficulty.	Participant 6 RJ facilitator 472-478
		I suppose I kind of knew where he was in relation to readiness, just to be able to talk through difficult issues, have conversations about his behaviour; I knew from my direct clinical work with him that he was ....., he was sort of in a place to do that, it was a bit hit and miss, but, you know, it wasn't too far away. And the other side of was the conversation with the ward manager immediately after we'd seen it happen and that was part of the discussions, you know, do we think he'll be able to tolerate that being immediately being picked up on. And his Care Coordinator was in the room as	Participant 7 RJ facilitator 130-139

		well, he had a quick confab with me in the ward office. Everybody felt that he was able to take part and able to tolerate it.	
	<b>Assessing risk</b>	... one of the first service users to volunteer for an RJ intervention was someone whose offence was stalking, and they wanted to be able to have contact with their victim and of course that threw out huge complexity where there was the possibility that volunteering for a RJ intervention was in fact an offence paralleling behaviour and was the risk of revictimization. And those sorts of dilemmas have been introduced in the risk assessment documentation	Participant 1 RJ facilitator 804-810
		... these individuals who have stalking profiles, who as part of their mental illness, are expressing an interest in the process and looking at RJ for making contact with the victims, and it's about how do you manage that...	Participant 2 RJ facilitator 224-227
		And I also wanted to know what safeguards were necessary for me, into taking such work, and also how could we plan it so that it was safe but productive and purposeful	Participant 5 RJ facilitator 86-88
	<b>Engendering trust</b>	... making sure that people that are being considered for RJ as an intervention are fully aware of what it is, what it comprises of, and are kind of almost aware of what they letting themselves in for, and that the preparation starts even at the point that they're being thought about the potential of it. So the person that is informing them should be someone who actually has a really good idea of what's it's all about, because otherwise you end up in a really tricky situation.	Participant 2 RJ facilitator 151-157
		I also think that in some ways, having a relationship of some sort enables the individual to have some kind of safety measure as well, that if they have a rapport with you and they feel contained by you, that could work as well.	Participant 4 RJ facilitator 139-142
		I do trust him as a professional. You know, he was impartial and talk about very, .....very.....um..... very seriously.  He seemed .....um.....sufficiently confident in what he was doing and it seemed very important to him, his role .....um.....that I had, you know, I had faith that he would perform his role, you know, with impartiality	Participant 8 Patient 98-100  207-209

<p><b>The impact of mental health problems on the process (T5)</b></p>	<p><b><i>Flexible timescales</i></b></p>	<p>And so from a clinical point of view, it became highly questionable as to whether or not this was the right time to be proceeding or to be putting the person under new pressure</p> <p>I think in terms of the service user's recovery to the point of being able to proceed again, that needed to be as long as it needed to be.</p>	<p>Participant 1 RJ facilitator 263-265</p> <p>444-445</p>
		<p>I mean that's not just a question of us not being able to give the time to it that it needs, it's also where the patient is at the moment. You know, you kind of get, ..... you do have those frustrations around, you feel like there's very clear work that could help move somebody on, that actually the person themselves is just not ready to do, not willing to do yet, so.</p>	<p>Participant 7 RJ facilitator 316-320</p>
	<p><b><i>Continuity across settings</i></b></p>	<p>And so they were re-admitted to conditions of medium security under a formal recall under the mental health act... And that introduced an additional complexity in that, the team who had been facilitating or involved in restorative process, and my role and the organization, meant that I didn't have direct access to a clinical team, and I wasn't in a position to necessarily keep an eye on or influence or shape a decision around when the service user might be ready to re-engage.</p> <p>... and the service user has since been transferred to another unit in another part of the county and so that momentum has been dispersed around that, and hasn't proceeded.</p>	<p>Participant 1 RJ facilitator 261-270</p> <p>543-545</p>
		<p>... and you know, I basically hadn't heard anything for the last 8 months about that, so this whole process, you know, has been left hanging in mid-air.... and... that's not very useful to me.</p> <p>And the fact that this whole thing's been left hanging and I don't know why or if ..... or whether there will be completion</p>	<p>Participant 8 Patient 135-137</p> <p>289-290</p>
	<p><b><i>Making sense of relationship between offending and mental health</i></b></p>	<p>I think the... perhaps the biggest kind of core issue around the RJ process in terms of him seeing it as a useful process, was him taking full responsibility for the offence but also his, for himself, his understanding the offence was that, at the time, he was experiencing very extreme psychotic symptoms which were... the end of a long period of years where he'd been experiencing those kinds of symptoms where he'd repeatedly asked for help. And I think, for him he felt like his family didn't really want to accept... they didn't understand what was happening for him, and so he felt very very isolated. And I think his understanding of the offence was</p>	<p>Participant 6 RJ facilitator 62-77</p>



		<p>that it was like a build-up that had happened over years where he couldn't cope with what was happening, you know, he wasn't getting the kind of help from mental health services, but neither were his family... although his family were supportive, they weren't, they didn't really understand what was happening. So for him, he saw himself as fully responsible for having committed the offence, but the context of that was that he was at a stage where he was really really unwell</p> <p>I felt quite strongly that it was going to be quite tricky working with it here. I think in particular because of the... you know the kind of mental illness aspect, so I think, quite often people's position is, well you know, they get to a point where they, you know, thinking that they're in a quite a strong phase of recovery, and they're looking back and kind of seeing what, you know, often quite violent offences that they've committed and saying; 'Well that was a point where my mental health had broken down'. And I think that is quite a big complicating factor, certainly in terms of shame. And I could see it was, you know, that was kind of coming up with the person I'm talking about. So, I think for him, you know, it becomes quite confusing how, you know you've done something and you can feel ashamed of it, but how do you kind of work with that when you've also got an idea that you were so affected by things out of your control due to your mental health.</p> <p>And, it's, you know, it's that kind of language which within an RJ process where you've got people who are very much saying, I know, I did this and I think it's just kind of working with the kind of complications of that, and I guess working from the, you know very much from the, from what how the person is kind of construing things themselves, that there is, I think, there can be, you know, sometimes there's a great invitation for people to say: 'I was really ill'. So, I suppose, what it can do is kind of almost crack open some of that, which I think quite often here isn't really addressed. Someone was really ill and they did this thing. They're really ill so we actually sort out the illness and then they'll be OK and, you know, it's kind of...</p>	<p>217-229</p> <p>244-254</p>
		<p>..... the thing I was most nervous about was sort of confronting her with ....., she blames her mental illness on why she hits people and says that she sees demons in people. And I pointed out to her that I didn't feel that</p>	<p>Participant 9 Victim 87-90</p>

		was true, because she'd been absolutely fine with me all day.	
		I just said, I was sorry for doing that and I explained I was angry and hearing voices.	Participant 10 Patient 74-75
	<b><i>Being unwell not necessarily being a barrier</i></b>	<p>Despite his mental state he was able to hear what we were saying, he apologised for his behaviour; initially he tried to write it off as a joke, but then later he accepted that it had come off badly and it had made the occupational therapist very uncomfortable.</p> <p>He was able to take on board in a way that I'd half expected him not to be able to do, given his history of denial.</p> <p>And I get the very strong sense that there are people who could have benefitted from this approach, just think ....., you know, perhaps people who've been with the service for two, three years, done a lot of work, are ready to think about their offending in a different way, their victims in a different way. You know, I've worked with people who could do that work regardless of their offending .....,you know the seriousness of their offending history and regardless of their mental illness as well, or personality difficulties.</p>	<p>Participant 7 RJ facilitator 30-33</p> <p>65-67</p> <p>280-286</p>

<p><b>Positioning the intervention in relation to on-going therapeutic work (T6)</b></p>	<p><b>A) Assessing upon admission</b></p>	<p>we've also done a mental health specific risk assessment tool that has to be implemented as part of the process of assessing the service user and the victim for their appropriateness to be involved, and then the conference record, conference contract, we've introduced a database for recording when people have started processes</p>	<p>Participant 1 RJ facilitator 787-791</p>
		<p>part of the offence analysis program could be about having a restorative component to it, which, that's still in its infancy, we're nearly there, in the process of just finishing writing the manual, and then we plan to roll out that out</p>	<p>Participant 4 RJ facilitator 475-478</p>
		<p>In terms of working with someone's index-offence, I think there would be a way of working with it where it was kind of highlighted quite early on, and then kind of working with that and looking at the kind of timing of it and whether it's appropriate or not, and using that as a way of actually sharing information about the process. So I would see it as really part of what would be going as part of care planning and looking at someone's treatment path, that's where I'd see it</p>	<p>Participant 6 RJ facilitator 388-394</p>
		<p>The other thing that's changing, that's being introduced in May, June time is an Offence Analysis programme and one of the possible outcomes of Offence Analysis will be a Restorative Justice process, be it, working towards a conference or something else. So there'll always be a recommendation we'll use some of the Offence Analysis programme to assess readiness for that with the patient and if it feels like something that's got mileage then it will be a recommendation and moving forward we'll try to set something up around restorative justice</p> <p>I think we'll focus on Section 37-41's, perhaps, in the first instance to make sure that people become, you know, who've got that court disposal will, straight to hospital, will be expected to have thought about their offending and then, as a consequence, as I said, it won't be the only thing on the menu really, RJ, you know, at the end of that assessment there'll be a number of possible kind of interventions, some of them will be the typical group work, like anger management and substance misuse, but RJ will be ....., we've designed the programme to make sure that some of the questions and some of the concepts that you need to think about before you do RJ work will be part of the offence analysis programme.</p>	<p>Participant 7 RJ facilitator 91-97</p> <p>102-107</p>

	<b>A) Preparation over time</b>	We would need to be better as seeing the opportunities for doing preparatory that may help the service user to be ready for conferencing in a more systematic and organized way	Participant 1 RJ facilitator 696-698
		but I think just the clear message to me was the importance of having a lot of time and a lot of preparation. It's probably the main thing I can comment on I guess at this stage  but we wanted to bring in an opportunity that if they wanted to meet and linking up with the probation VLOs, if they wanted to meet with their victim and both parties were in agreement	Participant 4 RJ facilitator 251-253  472-475
		one of the things about the RJ process, which is why I'd never go straight to a meeting anyway, is the unpicking and unravelling, because as they tell the story to someone else, it helps them think about it more, and if you do careful questioning, as they unpick the story, what happened, what were you feeling then, what were your thoughts, they start to think about it more	Participant 5 RJ facilitator 377-382
		I think perhaps the preparation is going to be critical	Participant 6 RJ facilitator 267-268
	<b>B) Acting quickly but with due preparation</b>	I think the misconception on the wards is that it's a bit of a chat, and that kind of fixes things. I don't think people have quite got the understanding of the depth of work that's sometimes needed, not all the time admittedly, but at least preparatory work with explaining to the individuals what should be achieved.  I think we probably can work with it, given enough time in preparation. I think given half an hour with each individual there was no way you would be able to encourage someone to at least the possibility of hearing someone else's harm when they feel very much like the victim of the situation	Participant 2 RJ facilitator 59-63  182-185
		I think some of the difficulties were about not having a long enough time frame in terms of the preparation compared to, I think the training that we were given	Participant 4 RJ facilitator 33-35
		I thought this would be a good opportunity to kind of respond quickly to what he had done and to make sure that it was clear that the, .... that his actions hadn't been appropriate, that we wanted him to be able to reflect on that and, you know, literally within the hour rather than it being presented to him during a ward round, some weeks in advance or something	Participant 7 RJ facilitator 12-16
		And so yes, I think that gave me the confiden .....and it was done so quickly as	Participant 9 Victim

		<p>well. I think that was the other thing, it wasn't, "Let's give it 24 hours to think about. Let's get on with it now, I'll clear something in an hour and we'll do it "</p> <p>But yes, I suppose that ....., I think maybe just, ..... a bit more kind of information about the process, about, you know, I only had a couple of minutes to think about something I could get her to do that would make me, or the ward, feel better, which was a bit difficult in a secure unit. It's not like they can clean the kitchen or ....., they can't do anything like that</p>	<p>154-157</p> <p>271-275</p>
	<b>B) Judging when not to use RA</b>	<p>I think on the admission ward there's often so much going on that it would be hard to kind of, you know, set something like that up, and people often, you know, they're quite unsettled when they arrive, and that's when assaults might be more likely to happen. So I think, you know, it's quite a difficult to do on an admission ward really. Unless it's someone who's been on the ward for quite a period of time. But I think on the other wards, perhaps on the women's ward as well, it might actually work quite well I would think... we tend to have people there who are staying there for quite a lot longer.</p>	<p>Participant 6 RJ facilitator 339-347</p>
		<p>I don't think it should be all the time, because some are like little assaults and like pushing someone and that. But when it's a big incident, yes, it should be.</p>	<p>Participant 10 Patient 247-249</p>
	<b>B) Recognising offence paralleling behaviour</b>	<p>Because there was the possibility that in making that complaint, and in the manner in which it was made, that there was offence-paralleling behaviour, and so from the point of view of the clinical team, there was a concern that the patient having made that complaint was an indication of an increase in her risk.</p>	<p>Participant 1 RJ facilitator 76-79</p>
		<p>So there was, you know, I think, in that sense, it was very clear in parallel with his offending, because he'd said something very similar about the OT, that he thought she was his girl friend and that he'd had children with her at that moment so he put his arm round her and asked for a kiss. He thought that was entirely appropriate, because of this sort of delusional fantasy. So, it was pretty clear that it was a continuation of that thinking</p>	<p>Participant 7 RJ facilitator 52-57</p>
		<p>and they felt that, because I had no trust in them and no faith in them it mirrored my circumstances prior to the index offence</p>	<p>Participant 8 Patient 109-111</p>
	<b>B) Integrating with care planning</b>	<p>... my primary sense of loyalty and obligations was to the clinical team and to the good governance of the organization, although it might be that I was mistaken in</p>	<p>Participant 1 RJ facilitator 592-597</p>

		<p>this but I was also trying to maintain what I thought was a duty of care towards the patient in her recovery process, and that included her mental health recovery but also her recovery from her vulnerability to re-offending.</p> <p>The facilitator sent to me a write-up of how the meeting had progressed and that immediately presented some dilemmas, because it felt like it was important, given that what we're trying to do is facilitate a risk reduction intervention for the service user, that actually that meeting is potentially an important therapeutic one, that may need to be documented in its own right. The clinical team needs to know that. But that boundary of transparencies while it was not necessarily clearly spelled out beforehand, and could have actually been very difficult to do, because the function of the facilitator was to be there in some ways neutral. And if there was simply going to be a naïve or transparent informer to the clinical team, then neutrality is compromised. But organizationally that is a tricky grey area for us because there are things that we would really rather prefer not to have withheld. It might actually be that the very thing that the facilitator feels silenced about is perhaps the thing the clinical team need to know most.</p>	560-574
		<p>Well, I think, particularly if it's residents, because I know how I felt emotionally, I'm a fairly together person, if that's how I felt, so if you've got person, either an in-patient or in the community, you know, 99% are emotionally fragile or some emotional difficulties or may have cognitive difficulties. When they come away from doing the sort of RJ bit, they're going to sit and ruminate and try to process some of those emotions and some of those thoughts and I think that's where the support comes in; they need somebody available.</p>	Participant 3 Victim 291-297
		<p>And also I felt that if I left this person with worries or concerns, even though that wasn't the intent, I needed somebody that she could access, who could continue to support her afterwards. So that was important</p> <p>But I think if we're talking about patients who are in treatment, then it can't be stand-alone, because I think that a patient may be in a certain state when it could happen, and in a certain state when it couldn't happen. And so therefore it can't be stand-alone, it's got to be as part of a total process. And I think the idea of doing things more with them, instead of to them or for them, is critical. So</p>	Participant 5 RJ facilitator 126-128  532-542

		the more you can engage them on reflective thought about whether they have the capacity to continue with thinking or not I don't know, but as a one-off process and perhaps an opportunity to fall back on it later on, I think it's invaluable, so it should be part of a treatment.	
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<p><b>Power dynamics and processes within the organisation conflicting with or confounding RA (T7)</b></p>	<p><b><i>Organisation as perpetrator</i></b></p>	<p>...it became clear that, from the feedback from the facilitator to me, it was that actually that this was more complicated than might meet the eye, and that there may be a need, if we are able to proceed to the conference, for the organization to be represented in that process</p> <p>Actually, the staff member was arguably more offended by the organization than they were by the service user. Because of how it had been dealt with organizationally</p> <p>Yes, and I guess I suppose where the question what is it that they were victims of, that it was in some ways partly the organization,</p> <p>... what I'm realizing through having participated in this process, that it will be much more complicated and much more challenging for the organization than it realizes, because it seems as if it's not going to be possible for the organization to be neutral in mediating the daily disputes or conflicts that may happen for example between service users. For example if one service user assaults another service user, and we introduce a restorative process and a conference perhaps about that event in order to promote victim awareness more broadly, there may be ways in which the organization is responsible for why those two service users were at loggerheads. So the way in which we failed the service user making them angry, they took it out on a fellow service user because that's what happens. That actually we are not neutral in the way that we may be when an external victim is involved.</p>	<p>Participant 1 RJ facilitator 231-234</p> <p>290-293</p> <p>309-310</p> <p>715-726</p>
		<p>But I wasn't quite sure how it would work in that particular situation, because I felt both myself and the client, we were both victims. I think I was a victim of her abuse and being sort of let down by colleagues and I felt she had been let down by the service, so we were kind of both symptoms of the same, ..... the same issue really.</p>	<p>Participant 3 Victim 43-47</p>
		<p>But quite often, as it unfolds, as this one unfolded, they became two victims of mismanagement, lack of support, for everyone involved, lack of guidance for everyone involved, which then became an issue, and so when I decided that a meeting, a conference meeting could take place, it needed to be between the nurse and the management, not between the nurse and the patient</p>	<p>Participant 5 RJ facilitator 338-343</p>



	<b>Pressure for a 'quick fix'</b>	It just felt like someone on the ward heard about restorative justice and thought: 'Right this could sort out this problem. Let's ask someone to do it. Go!'	Participant 2 RJ facilitator 44-46
		I think some of the difficulties were about not having a long enough time frame in terms of the preparation compared to, I think the training that we were given by *** and the need, the importance of lots of preparation. I was given a very very tight turnaround. In fact that member of staff was returning the following day, and they were sort of saying 'Could you do it tomorrow?'	Participant 4 RJ facilitator 33-38
		I think it's a slow process in a sense that different management groups within the one service have to approve it at different levels. And that's a slow process. And convincing people who haven't been part of the initial training process, perhaps don't necessarily see it in the same way. It's not a quick fix, it's not a pill, and as such, it's not an instant solution, but I think it's a more lasting one.	Participant 5 RJ facilitator 547-552
		... then I'm not sure that people who make the decisions about where the interventions will go, like responsible clinicians for example, they're usually looking for a quicker fix than perhaps RJ represents, I think there's a bit of a, ..... a bit of work to do there about how they'll, you know, how they comprehend Restorative Justice approaches. And right now I think they seem them as a sort of complicated, time consuming ....., you know, they're not a tablet, they're not something that can be done instantly. And both medication and punishment sort of fit into that instant category really, you can do them. They're quicker responses, not necessarily better.	Participant 7 RJ facilitator 236-243
	<b>Potential misuse</b>	... we would have been implicated in trying to potentially silence a complaint, organizationally. So, tricky. Now I'm trying to remember the next step. I approached the service user to make them aware that I was aware of the complaint having been made, and whether she would be willing to consider a meeting with the restorative justice facilitator, to see whether there was a way in which it could be resolved, and that no way was she compromising or withdrawing her right to continue to pursue a complaint in the formal channel, but that there may be an opportunity for reflecting on the process that may be helpful, and she agreed to that.	Participant 1 RJ facilitator 204-205
		I don't think it had been accurately portrayed to them before they were asked to come into the meeting, about what the process wasn't about where it would look at resolving it, I think it'd been sold almost as part of the investigation disciplinary process. Which I was very disappointed about, that it'd been	Participant 2 RJ facilitator 115-123

		sold to someone in that way. They were wanting us as facilitators very much to make a decision, and to say 'Yes you can come back to work' you know, or to look at very clearly putting plans in place for them and I don't think that's the role of the restorative justice facilitating that process...	
		The investigation had completed to the point where the member of staff was found not to be guilty of doing that, and the actual patient had retracted their statement at the time as well and said: 'No, you know, I made it up'. So it seemed like an appropriate thing to do because my first concern was, if that investigation was still running, that perhaps it wasn't the best timing to then start with a restorative approach, and that maybe it should be after that incident, but it seemed appropriate to get involved	Participant 4 RJ facilitator 19-26
		I was told about lacking a resource problem; they seemed to use it as a tool, they seemed to want to use it as a tool for their own advantage and not as it should be used.	Participant 8 Patient 442-444
	<b>Coercion</b>	... and I think also, you know, in this setting because people do, you they're incarcerated, and so their sense of whether this is going to be something that they have to do to then get out is another factor which is quite a difficult one.	Participant 6 RJ facilitator 268-271
		And I agreed to it, because I really felt afraid, you know, of how, you know, if I didn't that....., I knew that my .....um....., my discharge, my continued discharge into the community, my placement in the community did depend on the community team and so I felt, you know, that I'd be putting myself in jeopardy if I didn't agree to it.  I felt I had to be doing it, otherwise it would affect my discharge	Participant 8 Patient 77-81  259-260

## The Implementation Process

<b>Change drivers (T8)</b>	<b>Individuals</b>	I'm having to try and manufacture time to try and push things forward and that means that it's in fits and starts. And that the other people who are trying to do it as well are trying to introduce something that is, as I think I said before, a bolt-on	Participant 1 RJ facilitator 743-746
		... it was *** that had been looking at Restorative Justice for this service...	Participant 3 Victim 38-39
		The other thing that a colleague, *** and I, are working on, an offence analysis program, where we're going to, we've actually implemented RJ as a part of that.	Participant 4 RJ facilitator 465-467
		what I guess is what *** is trying to do, is kind of that, that kind of initial pushing it so people see it. But I don't think it hasn't yet...	Participant 6 RJ facilitator 410-411
	<b>Motivation to repair</b>	so I was concerned that anything that came out of that would have dam...., completely damaged that relationship	Participant 3 Victim 115-116
		... we talked about it a little bit but he wasn't too motivated, I think he was in a place where he was, you know, quite fearful in general and just wanted to kind of move on from it	Participant 6 Facilitator 317-319
		Because I want to have, .... when I am discharged again I want to have a very good relationship, you know, with my CPN, my social worker, my consultant.	Participant 8 Patient 411-412
		And her sort of history is that afterwards she sort of said, "Sorry", but then she still assaults staff and so I didn't really want it to be just we come in, have a chat, just the two of us, she says, "Sorry" and then continues to do it. I wanted it done in a more kind of structured and therapeutic way.	Participant 9 Victim 10-14
		INTERVIEWER: Yes. Yes, what were you worried about?  INTERVIEWEE: That she wouldn't forgive me.  INTERVIEWER: Right. And you wanted to be forgiven?  INTERVIEWEE: Yes.	Participant 10 Patient 24-30
	<b>Positive research evidence</b>	... because restorative justice now has got such a profile in society as being promoted, it's recognized as an intervention, it's recognized as being an offender specific	Participant 1 RJ facilitator 709-712

		intervention, that it essentially has the organization credibility to be taken up.	
		... but I knew about Restorative Justice anyway, because it's something I'm interested in.	Participant 3 Victim 42-43
		I've had belief in RJ for a long time actually. I used to work in the Youth Offending team when RJ came out in 2000? So that was when I first had an introduction to it. I wasn't working in the team that was involved in getting it set up but I was very kind of interested in that work at the time.	Participant 4 RJ facilitator 383-386
		I've been doing it now for ten years, in a whole range or different situations, and very hurt and bruised and damaged people, families, establishments, individuals, and I think I've seen how amazingly people can move on from situations where they never thought they could	Participant 5 RJ facilitator 578-581
		I thought it was a very good idea and I'd read .....um..... a little bit about it in the criminal justice system and how well it could work.	Participant 8 Patient 243-244
		Well, as I say, I did a lot of it for my criminology degree, back in the day. And it was very favoured. You know, lots of research on Restorative Justice and its benefits.	Participant 9 Victim 358-360

<b>Implementation enablers (T9)</b>	<b>Positive experiences</b>	See previous quotes relating to: “Powerful and positively transformative” “Instinctually and intellectually appealing”	
	<b>Growing number of supporters</b>	See previous quotes relating to: “Generates ‘converts’”	
		I’ve been discussing with his probation officer who is trained in RJ, luckily, about how in the future we could potentially support and facilitate that.	Participant 2 RJ facilitator 253-254
	<b>Pre-existing relationships</b>	. I also think that in some ways, having a relationship of some sort enables the individual to have some kind of safety measure as well, that if they have a rapport with you and they feel contained by you,	Participant 4 RJ facilitator 139-141
		because I don't think he sees me as his therapeutic ally  it's very helpful to have prior knowledge of the person	Participant 7 RJ facilitator 160-161  176-177
		Because .....um.....I trust G****, I think he's a very good .....um..... consultant psychologist.	Participant 8 patient 201-202
	<b>culture</b>	I think perhaps Willow, the women’s ward, that might be quite a good place, you know the environment there would support it better possibly, than the other wards	Participant 6 RJ facilitator 378-380

<p><b>Implementation inhibitors (T10)</b></p>	<p><i>Inertia</i></p>	<p>... and therefore there was the potential that it would be seen in a way somewhat suspiciously as to what is the services' investment in this, what is the people who lead on trying to implement the restorative justice process around this, why are you trying to do this when we proceeded perfectly well without it in the past.</p> <p>So that then introduced another way in which to have a sort of restorative process proceed, and that is then what I took back to the clinical team to say: do you think that the service user is in a place to do that, would you support that process of potentially meeting with a member of the care team in order to move on? And the clinical care team have not responded to that directly and so we haven't been able to move on with that, and the service user has since been transferred to another unit in another part of the county and so that momentum has been dispersed around that, and hasn't proceeded.</p>	<p>Participant 1 RJ facilitator 276-281</p> <p>537-545</p>
		<p>I think it's quite hard in what is essentially quite a reactive culture...</p>	<p>Participant 6 RJ facilitator 364</p>
		<p>I know one of the Social Workers has been pursuing a number of possibilities, you know, on a low secure ward and, ..... um ..... I don't really know why that's not working out; it's not proceeding and it's not progressed to a point where there's an intervention at work, even if it's not a conference, you know. As far as I know it's not got anywhere.</p> <p>Disappointment I should think, when we talked about it on the wards; the nurses have....., is it a surprise or a disappointment that nursing teams have tended to, kind of, hold on to their previous ways of dealing with difficult behaviours or difficult situations; there's been a quite defensive response to the idea of doing that a bit differently, from some quarters, but that's mixed experience, some people responded to the ideas of RJ very well. They've come to us with ways that they could be used But yeah, a bit disappointed... cling to the wreckage ....., you know, you do something over and over again, even though it doesn't work particularly well, but you don't, ..... you're not ready to let go of it. You want to stick at it because it's familiar, that's sometimes how it feels around the alternatives that RJ, you know, it just feels like they're well oiled or well used, and why would we change... It always surprises me how that can play out.</p>	<p>Participant 7 RJ facilitator 250-254</p> <p>292-303</p>

	<b>Not core business</b>	<p>... and so there was then a long delay where the complexity of the process and the fact that it isn't a priority task, we were trying to do other things as well, meant that there was a long gap between this service user's interview with the facilitator and getting to a position where there was a possibility of some resolution.</p> <p>But there are other ways in which there have been organizational delays that through inattention in it not been prioritized, not being able to persist at making things happen, and that even now that the service user has been ready to proceed, there's been more organizational delays and I think that what has happened is actually both parties have become frustrated, that both of their wishes to proceed, both of their wishes to be heard in particular way to have closure, have been frustrated and haven't yet happened adequately.</p> <p>... the organization has not freed me up to focus on this, I'm having to try and manufacture time to try and push things forward and that means that it's in fits and starts. And that the other people who are trying to do it as well are trying to introduce something that is, as I think I said before, a bolt-on and so, there isn't necessarily clearly dedicated time to make that happen. Things drift.</p>	<p>Participant 1 RJ facilitator 254-258</p> <p>445-452</p> <p>742-747</p>
		<p>You know, we know what we're supposed to be doing but seeking out the opportunities and having the time on top of everything else that we do, it's kind of putting into action... I think I'd be slightly anxious that we kind of lose sight of it.</p>	<p>Participant 2 RJ facilitator 351-354</p>
		<p>I hope it becomes something that we do as our core business really,</p>	<p>Participant 4 RJ facilitator 478-479</p>
		<p>I think that would need to be a priority in terms of kind of management...</p> <p>... that it would perhaps evolve as something that the service saw as useful and you know, then evolve to a point where it became almost like a core part of the work that we're doing. I think that would take some time...</p>	<p>Participant 6 RJ facilitator 377-378 406-409</p>
		<p>we have, you know, a ridiculous number of competing priorities in the service for what we do, day-to-day, with the patients and unfortunately that means restorative justice, it's not been embedded in the way that it ought to have been. Because there are only so many hours in the day, so a lot of our priorities are ..., have ....., I mean the bottom line is the priorities, the clinical</p>	<p>Participant 7 RJ facilitator 82-88</p>

		<p>priorities have financial implications, we have to deliver those, and if we don't there's financial penalties for the service. Restorative justice doesn't fall under that category so it's secondary in that sense</p> <p>But in relation to other patients, you know, it's a shame that there's just been one intervention .....and that we haven't been able to ....., there may be people on the ward now that are more able to tolerate that approach, can get something out of it, that we're not, ..... we're not pursuing, that's frustrating, you know. Something might be worth a go, might work with a patient, we just haven't got the current resource to get to.</p>	320-325
	<b><i>Fear of making things worse</i></b>	<p>But the clinical teams who aren't confident about our governance around this because it is new, feel worried that they could simply get to be manipulated by a service user into providing an intervention that is going to compromise everyone and not perhaps recognizing that they may be many steps before you get a conference, you may never get a conference, but there are restorative processes that may happen to expose the service user's lack of empathy in fact, or make that clear, and that would have been a therapeutic outcome that is beneficial</p> <p>... the fear of that going wrong is discouraging people from recognizing the other options, the full spectrum of processes that could be implemented</p>	<p>Participant 1 RJ facilitator 810-817</p> <p>820-822</p>
		<p>VLO is very clearly saying we don't want to re-traumatise the victim, we need to be really careful in our approaches to this which obviously we take on board...</p> <p>I think there's obviously huge variance in levels of seriousness of offence, and the potential impact it's had on victims, victims' families, you know victims' families when the victims died, and really sensitive situations even more so, and I think they're the ones that we're all slightly more anxious about in how do you as a practitioner deal with the victim of a serious offence, in that respect. It's something that we need to be very aware of.</p>	<p>Participant 2 RJ facilitator 264-266</p> <p>391-397</p>
		<p>... so I was concerned that anything that came out of that would have dam....., completely damaged that relationship.</p>	Participant 3 Victim 115-116
		<p>I think it might actually upset her more if she gets this from me or if it's even brought up again</p>	Participant 6 RJ facilitator 124-125
		<p>I think if RJ, ..... because we don't know what the affects will be ..... then, ..... it's possibly better to have,..... to have a</p>	Participant 7 RJ facilitator 184-188



		<p>separation, because then it doesn't interfere ....., you know, because if there is a negative outcome to RJ, then it doesn't interfere with the other therapeutic processes that are going on</p> <p>Well, I think it makes everybody a lot more nervous about the potential for a recycling of trauma for the victims, you know, it going horrendously and terribly wrong, even if you've done the prep, you know, and you add to that the unpredictability of a mental health diagnosis it just, really, it just exacerbates the anxiety around that.</p>	263-266
		<p>It's all very well me saying this to her at this meeting, she's looking at me like she hates me right now. When I leave, what's she going to do to me afterwards? Is she going to really hate me for setting this up? But I was given the opportunity to even say that to her and I said that to her in the meeting.</p>	Participant 9 Victim 98-101
	<b>Fear of vulnerability</b>	<p>and I quite quickly became subject of that restorative process, and therefore myself I felt quite vulnerable and potentially exposed as being, you know, talking the talk and not walking the walk</p> <p>she didn't want to proceed with a meeting with the service user, and felt that the reason for that would be that she would need to make herself vulnerable in order to explain how she felt, and she didn't want to be doing that, didn't want to bring herself in a position of saying: this is then how I felt. Because she, in some ways, still felt at risk from the service user</p> <p>I understood better why the staff member had been reluctant to put herself in a position of being in a restorative interview with the patient, and not wanting to make herself vulnerable in those ways, in the ways which she did allow herself to be vulnerable in the restorative meeting with me</p>	Participant 1 RJ facilitator 179-182  242-247  382-386
		<p>I can understand why at times they wouldn't want patients to hear their harm because they would feel it may make them more vulnerable, because if a service user knows how to cause harm to a member of staff or knows that a particular action or something causes another person to feel harm, then they could perceive that that would make them more vulnerable, in that ward's scenario.</p>	Participant 2 RJ facilitator 204-209
		<p>already felt extremely vulnerable just coming into work, because of possible physical assault</p>	Participant 3 RJ facilitator 104-105
		<p>And you know it's a difficult thing to do as a professional with a patient, as well, because you, you know, you're not just being a</p>	Participant 9 Victim 107-111

		professional, you're being a bit more human and you're being bit ....., it did affect me, you don't know whether she's sitting there thinking, "Ooo what a wimp", you know, "Well she's an easy target now", you know, that worried me a lot throughout	
		Nervous...That she wouldn't forgive me	Participant 10 Patient 22-26
	<b><i>Conflict with medical model</i></b>	And I think there are many factors which are almost like pressures not to do it, particularly in quite a medicalised system. You know a lot of the emphasis is upon managing mental illness, and people going out because they're perhaps you know, psychotic symptoms are controlled or apparently controlled, and I think, you know, the service pressures to move people along...  ... a pressure not to look at the whole complexity of someone's life I think, within you know, a kind of what is within a very strongly medical model.	Participant 6 RJ facilitator 290-295  303-304
	<b><i>reactive culture</i></b>	I think it's quite hard in what is essentially quite a reactive culture, which is driven very often by kind of immediate needs and changing needs	Participant 6 RJ facilitator 364-366
		That kind of temptation to use rules as a way of retaliating against the sort of behavioural difficulties	Participant 7 RJ facilitator 211-212
	<b><i>Practicalities/bureaucracy</i></b>	... this is where it's actually important to mention what my team like, trivial organizational details, but it's difficult enough to get through people's diaries to coincide, we then also have got the restrictions perhaps on room bookings and how long we can have a room, and where it is that we're going to meet, because we all came from different parts of the county in order to meet, and that meant that there was a time parameter of the meeting  ... is developing and a victim perpetrator leaflet to inform them about the RJ processes, how it fits in within the service, that's kind of caught up in bureaucracy at the moment because it has to have the Trust's standard of approval...	Participant 1 RJ facilitator 362-368  783-786

<p><b>Processes to support psychological and organisational containment (T11)</b></p>	<p><b><i>Establishing protocol</i></b></p>	<p>It just kind of highlights in a way the degree to which there needs to be almost a kind of case file opened for the process, because you never know, there are unpredictable that happens, and there are side eddies and things that happen that you never realize the number of tasks that emerge from each potential action point, were substantial. And you can easily lose track of them.</p> <p>So that presented dilemmas about disclosure, how much about the patient's current circumstances can be disclosed at this point in order to try to help the victim make an informed decision about why this is happening. But also the difficulty in negotiating with the victim about what they are prepared to have disclosed to the perpetrator about what their view is. So what we're finding again is that they're very complex dilemmas surrounding confidentiality that are making things difficult.</p> <p>we've also done a mental health specific risk assessment tool that has to be implemented as part of the process of assessing the service user and the victim for their appropriateness to be involved, and then the conference record, conference contract, we've introduced a database for recording when people have started processes</p>	<p>Participant 1 RJ facilitator 552-557</p> <p>769-776</p> <p>787-791</p>
		<p>Who has that final say in where that intervention is?</p>	<p>Participant 2 RJ facilitator 286-287</p>
		<p>The other aspect I guess was thinking about what gets written up after,</p> <p>The other thing that a colleague, *** and I, are working on, an offence analysis program, where we're going to, we've actually implemented RJ as a part of that.</p>	<p>Participant 4 RJ facilitator 253-254 465-467</p>
		<p>And I think one of the things about working in a setting such as this, which is new to me, although RJ isn't new, I've been developing it for a number of years, was you can let some thoughts out, feedback is very slow, feedback doesn't always happen, and you don't know what's been done with the information you've given. And sometimes that information requested action and no action happened. Or you weren't aware of what action happened... Not disinterest. I thought there was a lot of interest. A lot of it was down to departmental areas, so this wasn't my department it was somebody else's department. Areas of authority over which people don't always have input. I think it was largely that.</p> <p>It's the way that perhaps large organizations,</p>	<p>Participant 5 RJ facilitator 186-210</p> <p>225-228</p>

		<p>which I'm not very familiar with, because it involves different teams, different areas of responsibility, and everything like that. And people have to get approval from different areas and different individuals, but it's harder to achieve.</p> <p>I would like to know named people that I could have dealt with more directly, which may have elicited a more direct response</p>	247-249
		The other thing that's changing, that's being introduced in May, June time is an Offence Analysis programme and one of the possible outcomes of Offence Analysis will be a Restorative Justice process, be it, working towards a conference or something else.	Participant 7 RJ facilitator 91-94
		I think it should almost be sort of written in the policy that that's what, you know, happens after an assault.	Participant 9 Victim 350-351
	<b>Disseminating information</b>	... developing and a victim perpetrator leaflet to inform them about the RJ processes	Participant 1 RJ facilitator 783-784
		<p>I think the misconception on the wards is that it's a bit of a chat, and that kind of fixes things. I don't think people have quite got the understanding of the depth of work that's sometimes needed, not all the time admittedly, but at least preparatory work with explaining to the individuals what should be achieved.</p> <p>... so I think there's still a lot of education work to do with the wards in relation to what the process is, what purpose it serves, where the roles and boundaries are...</p>	Participant 2 RJ facilitator 59-63  123-125
		I don't even know when it's going to be rolled out, who's going to be doing it, if it's going to be available in the community, absolutely nothing	Participant 3 Victim 311-312
		I'm going to run a session where I have an academic slot which I'm going to run a session where I talk about RJ to all, cause there's 3 units where I work, so trying to gather the staff and sort of raise awareness, raise the profile. I know that we're in the process as well of... we've got leaflets and material that we're promoting and thinking about using which I think will help. So I think that's been a barrier that some people probably don't really understand it, or know what it is	Participant 4 RJ facilitator 458-465
		I think it's about the other staff having information about it, and being just quite proactive about making conferences happen as they come up	Participant 6 RJ facilitator 375-377
	<b>Changing culture</b>	So, the clinical team, I think, where they didn't hold at the forefront of their minds the idea that we're looking to see when the	Participant 1 RJ facilitator 270-276

		<p>patient may be ready to re-engage with a restorative process that may help to support her to be back in the community, because their goals and their therapeutic aims were focused elsewhere, this process being a new one, wasn't on their radar. And so, it always felt as if it was a bolt-on to what the clinical team were doing</p> <p>... we as an organization would need to become more focused on restorative processes than I think we are. We would need to be better as seeing the opportunities for doing preparatory work that may help the service user to be ready for conferencing. In a more systematic and organized way...</p> <p>It feels to me that restorative processes being embedded in the organization create the opportunity for a re-iteration or a re-emergence of the principles of therapeutic community, but perhaps without all of the constraints and the trappings and the requirements that brings with it,</p>	<p>694-698</p> <p>703-707</p>
		<p>And I think that the more that some staff and certainly one or two of the staff that were part of the training program, I think are starting to introduce it not necessarily formally but informally in their language, in their actions, in their behaviours, and that is a level which is really very beneficial to everybody.</p>	<p>Participant 5 RJ facilitator 505-509</p>
		<p>And I think it could feed into the culture quite strongly, you know, if that almost became part of just what happened after that kind of incident people were in that... I think, you know, that could be quite a strong carrier of culture actually.</p> <p>I think, you it needs a kind of strategy that perhaps might be about getting it kind of working on one ward in particular, perhaps targeting a ward where there might be staff who've done the training, who are motivated to do it and you know, I think it's about the other staff having information about it, and being just quite proactive about making conferences happen as they come up.</p>	<p>Participant 6 RJ facilitator 354-357</p> <p>372-377</p>
		<p>... that's the first way in, I think the other way is the one you alluded to when we start to support staff to recognise moments on the ward where something's happened, perhaps between staff or between a resident and a member of staff, where you can use an RJ model to address that and think about the harm done and the ways to make amends. Rather than it being just a question of penalising the patient for a certain behaviour.</p>	<p>Participant 7 RJ facilitator 115-120</p>

<b>Challenges ahead (T12)</b>	<b>Maintaining skills of facilitators</b>	Bear in mind, this was our first attempt really to try to run some sort of restorative process and gain experience in implementing it.	Participant 1 RJ facilitator 192-194
		I think things that are going well are having the opportunities to meet as a sort of practitioners' group, and to talk about how we're going to take things forward.  I think frustrations, in that there haven't been as many opportunities as I'd like there to have been, you know it's one of those things you want to get on with it and start trying to put things into practice to see if they work, to see if you've got the hang of it, and I guess that's a frustration that I haven't managed to do that as it... And confidence comes in around that you know, because you know, by the end of the training, you're happy role-playing away and, you know, being someone's dad or whatever, all of sudden you're like: 'Oh I've forgotten quite what the language was, and how to phrase that, and what order things go in so having the tools to go back to refresh that is really important.'	Participant 2 RJ facilitator 346-348  437-450
		What concerns me is the level of training that the staff here would receive. The opportunities for them to be able to use that, to kind of mature in what they're doing and ongoing training as well. That it wouldn't be just a case of, "Well we trained you in that, so that's it". Because, having been on the sort of receiving end, if you like. You're dealing with people who're sometimes kind of very fragile state. It's a, ..... how it came across to me, it's a hugely skilled thing to do	Participant 3 Victim 245-250
		I was kind of looking forward to it, having, practising that really, the skills that I'd learned	Participant 4 RJ facilitator 250-251
		I think working in a establishment such as this, you need a bit of success before you started here perhaps, you know your own ability to do it, which is why I've suggested that when people want to start doing bigger conferences or bigger things, I'll come and support anybody who's doing it.	Participant 5 RJ facilitator 613-617
		The only thing that's gone badly, is ..... that they're not getting any practice, because of competing demands and so that training will start to degrade	Participant 7 RJ facilitator 228-230
	<b>Demonstrating effectiveness</b>	... that the intention is there and the team of people that are wanting to do it are sort of willing and able, but the opportunities aren't found or the ones that are found don't have the outcome that decision-makers want them to have. And they may not be able to see concrete results that would lead to it being apt to continue and it would kind of fall at those hurdles	Participant 2 RJ facilitator 355-359
		*** said I need to speak to **** who's one of our directors about funding for this. I was a	Participant 3 Victim

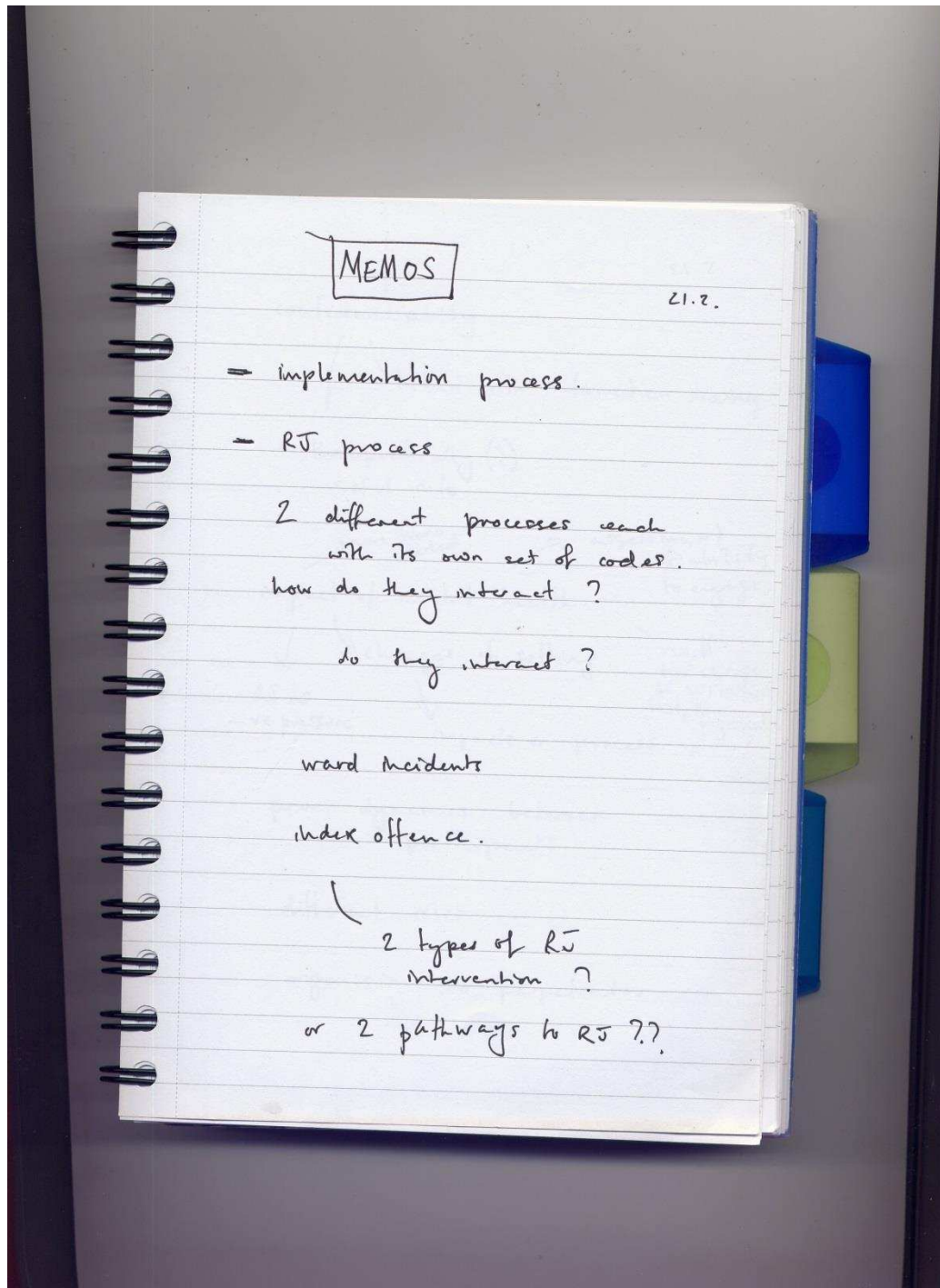
		bit cross and said can you say to ****, she can't afford not to fund it, because actually, if I'd gone off sick through this, it would have cost an awful lot more than sort of going through it	128-131
		... it's more kind of trying to demonstrate the usefulness of it. I think if a couple happened, then I think that might be the turning point, then it might kind of evolve from there if they were seen as useful and, I think that is needed before it can kind of get to the next step.	Participant 6 RJ facilitator 413-417
		It is a bit of a blank slate, isn't it? Because there's been so little done in mental health...	Participant 7 RJ facilitator 188-189
	<b><i>Establishing links and procedures with partner agencies</i></b>	What is also very complicated is that because there are these links externally to police and probation, victim liaison officer, victim liaison teams, and the wider Trust, there are many relationships that need to be negotiated in terms of our partnership working with them. And because it's a new novel area which people are uncertain it's something that has to be done carefully and in a consultative way in which we don't presume a partnership working. What that's meant is that we've as an organization we've actually got on with restorative justice processes, or exploring where it might be possible with service users where we don't need to ask anybody else's permission, where we don't need anyone else's say so, where our clinical governance around processes is one where we're confident we're holding as opposed to where we go externally where it's not clear who's facilitating,	Participant 1 RJ facilitator 747-758
		So I think it's still the early days of those discussions with them [VLO's]. But they seem to be interested in the thought of using it with our population of clients. I think it's just a case of working out the who and the when and the why and the how of, you know, who takes those forward and how they're going to work	Participant 2 RJ facilitator 295-299
		but we wanted to bring in an opportunity that if they wanted to meet and linking up with the probation VLOs, if they wanted to meet with their victim and both parties were in agreement	Participant 4 RJ facilitator 472-475
		... because the VLO was someone who's not RJ trained, so I think for her, to kind, she wasn't in a position to take that on to then kind of actually give the information about the process, what it was. So there's that kind of breaking the links, so the link was... I was talking to the service user here and also to his social worker to some extent, the social worker was liaising with the VLO. The VLO was kind of a bit, I'm not sure what, how this	Participant 6 RJ facilitator 99-107

		is going to help, so she wasn't in a position to kind of be talking to the victim in a way that was going to, you know, kind of pave a path to, you know, a constructive process.	
--	--	---	--



## Appendix 12

### Examples of memos



21.2.

confidentiality

linked with information sharing.

v. therapeutically (?)  
useful info.

more time needed?

assessment of ability to engage.

impact of mental health.

changes of setting.

will the change be sustained  
lost, then regained?

RS as -ve pressure.

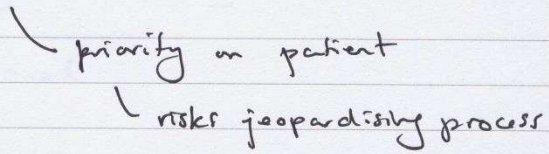
impacts on process.

power dynamics between participants.

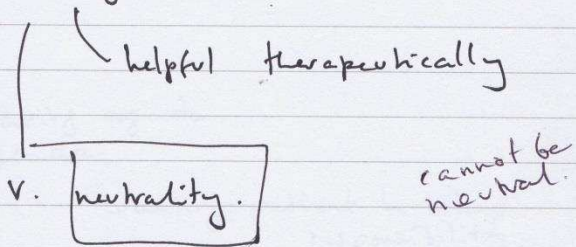
different roles.

organisation as perpetrator.

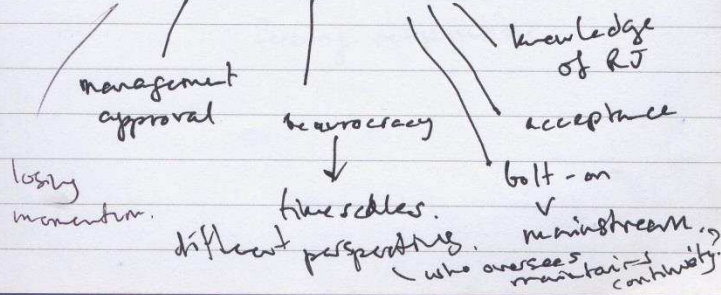
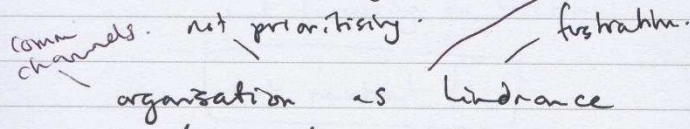
vested interest



knowledge of patient



offence paralleling behaviour.



29.2

choice — to use/offer RJ  
          — to participate.

— who oversees??

bolt on v integral.  
different goals? → other processes <sup>gone</sup> alongside

assessment of patient

ability to see others position.  
— { — benchmarked?  
          — able to use intervention  
          — evidence of engaging therap.  
          — not knowing.

therapeutic — <sup>victim awareness</sup> recognising own part  
          — recognise risk in future  
          — change coping behaviour  
          — more powerful when live  
          — transformative

Feeling heard

4.2.15.

enthusiasm !!

so much of it

↳ from all groups.

becomes a belief system.

- people converted.

8.3.

misinterpretation of process

or mismatch between what  
want and what RT delivers

4.4.

anxiety / fear

→ avoidance.

8.5

low frequency  
high complexity

how to maintain skills ??

IS #125 an appropriate intervention?

Does it fit? - for secure forensic services.

enthusiasm + belief in model

Yes

- ① makes sense
- ② fits with what is done
- ③ powerful yet safe
- ④ effective

⑤ what offender wants  
on occasion esp re  
index offence  
against family.

adjustments  
needed

- ① time
- ② continual assessment
- ③ level of complexity  
- adjusting model.

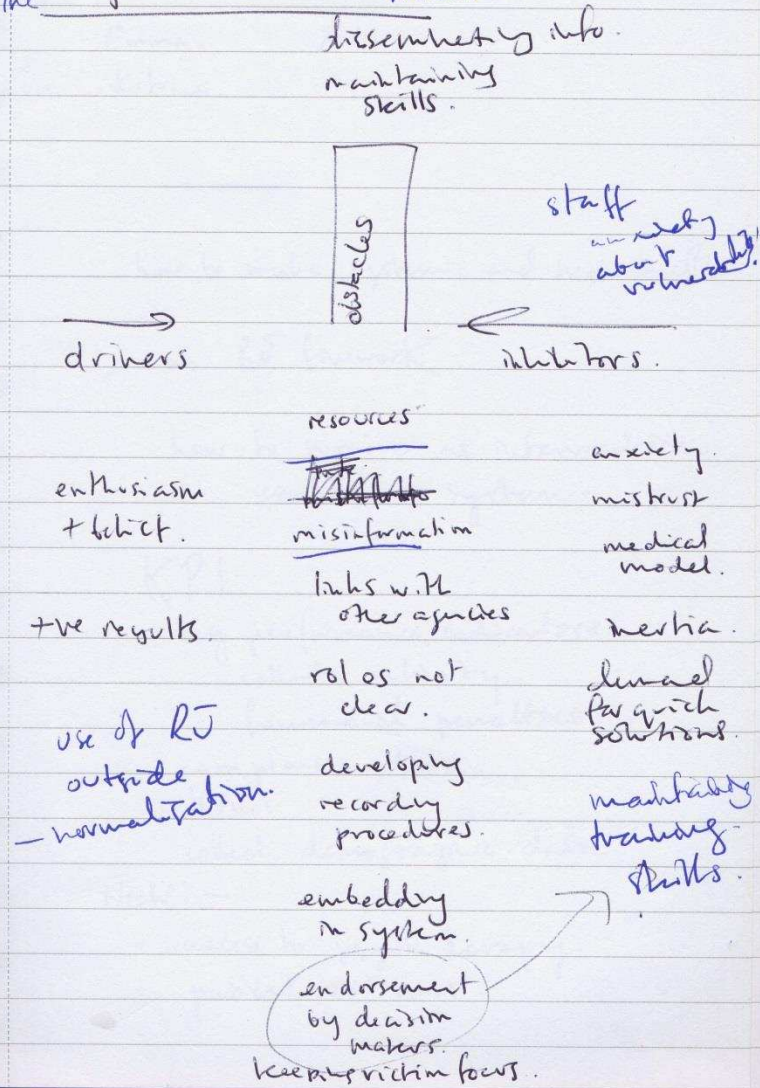
~~maybe~~

- ① co-ercion
- ② mis-use "patients eg stalking"
- ③ vulnerability of staff
- ④ misuse by org eg silencing complaints

difficulties

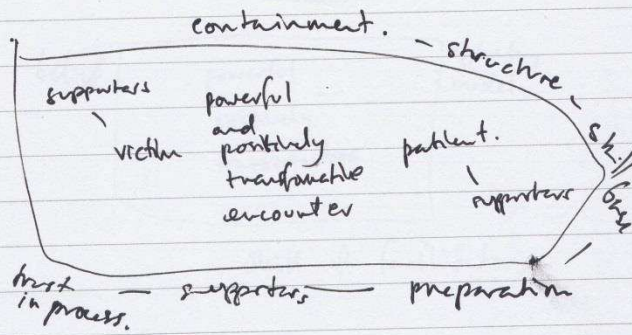
anticipatory anxiety.

lessons learned from: factors affecting the implementation process.





18A



## Appendix 13

### Diary extracts

11.8.11.

Yvonne.

Discussed title, questions, measures.

What is the impact of restorative justice  
on a forensic mental health  
population.

emotional well-being  
behaviour  
attitudes.  
relationships.

qualitative or quantitative.  
or mixed?

richness of material in interviews.  
→ drawn to that.  
+ fits with new field of research.

15.8.11.

safety

security induction

key carrier ?

alarm - personal and room

community - lone working policy  
escorted by key workers?

methodology ?

discourse - Foucault  
+ Parker

critical stance.

what are the silences

what's missing

grounded theory ?

IPA.

14<sup>th</sup> October

Silomons MRP review.

Sve Holtham & Dan

list of amendments and clarifications agreed.

project generally approved, - hooray!!  
dependant upon amendments.

rationale - more than not done before.

add to understanding of recovery pathway for mentally disordered offenders

advised no measures - not assessing whether intervention works but examining how.

\* social constructionist approach \*  
not seeking "truth" which is out there to be found.

4.11.11.

Meeting with Gerard.

progress and amendments discussed.

Ruth Rushton & Sarah Birch completed service user profile.

level 1 R5 already being used.

Rebecca Hills agreed in principle for staff training in R5 for Jan/Feb.

Amanda Tuckey (s/w) - communication with victim liaison.

Additional info for Selomans approval gathered.

18.11.11

Project approved,



26.1.12

Bracketing interview (Mett)

drawn to subject - fits with previous knowledge - capacity to change, making good, turning life around, Shed Marina etc.

feels 'real', 'meaningful' - hard to explain this - real to society in terms of impact, also to individual - 'dramatic'? 'machi'?

why forensics? family influence - science, wanted to be forensic scientist aged 12 - solving puzzles - grew up with sound of Broadmoor siren - fascination - danger / excitement / unknown.

intervention - RJ - fits with personal beliefs / ethics - want it to be successful - making good rather than punishment -

can it provide a transformative experience? I hope so !!

1.2.12

meeting with Gerard

love his enthusiasm

- v. motivating

he has been telling people about the research and seems so pleased to have it - great to hear that

Yvonne has been out of contact.

Seems strange - worried...

Paul C now agreed to be internal supervisor

IDAs form progressing - G gave useful comments.

Parentic theme still not accepted by Trust - worrying - G seems confident though. I have checked up with email to Bryan.

Training not yet agreed but G does not envisage problem.

theme refused being challenged by submitting research proposals.

whole theme model based on

making money from privatized companies - not enough room for innovative thinking

new build going fri.

recovery approach (not model) model operationalises approach.

possibility of transferred prisoners - ethical implications??

18.2.12.

Turned down by R&D. PAnnie!  
And disappointment.  
And frustration.

- he suggests classifying as  
service evaluation which would not  
need R&D approval. - but its not  
feel a bit powerless caught up  
in Trust dynamics.

18.2.12.

Gerard had sent a very  
supportive & challenging email

- (1). restating it is research  
but of qualitative nature
- (2). forensic theme still  
being pursued.

Feeling more hopeful again.



5.7.12

Ethics panel. Not so bad. Feel like I have more of a grasp of the issues as time progresses, so was able to answer questions and talk competently about the risks etc. Some concern regarding using RT with the population - had to make clear that this was happening independent to my research - that I wasn't making the decision to do this. Also discussion about how to clearly separate the 2 processes (RT and research) in terms of capacity & informed consent. Useful conversations.

17.1.13.

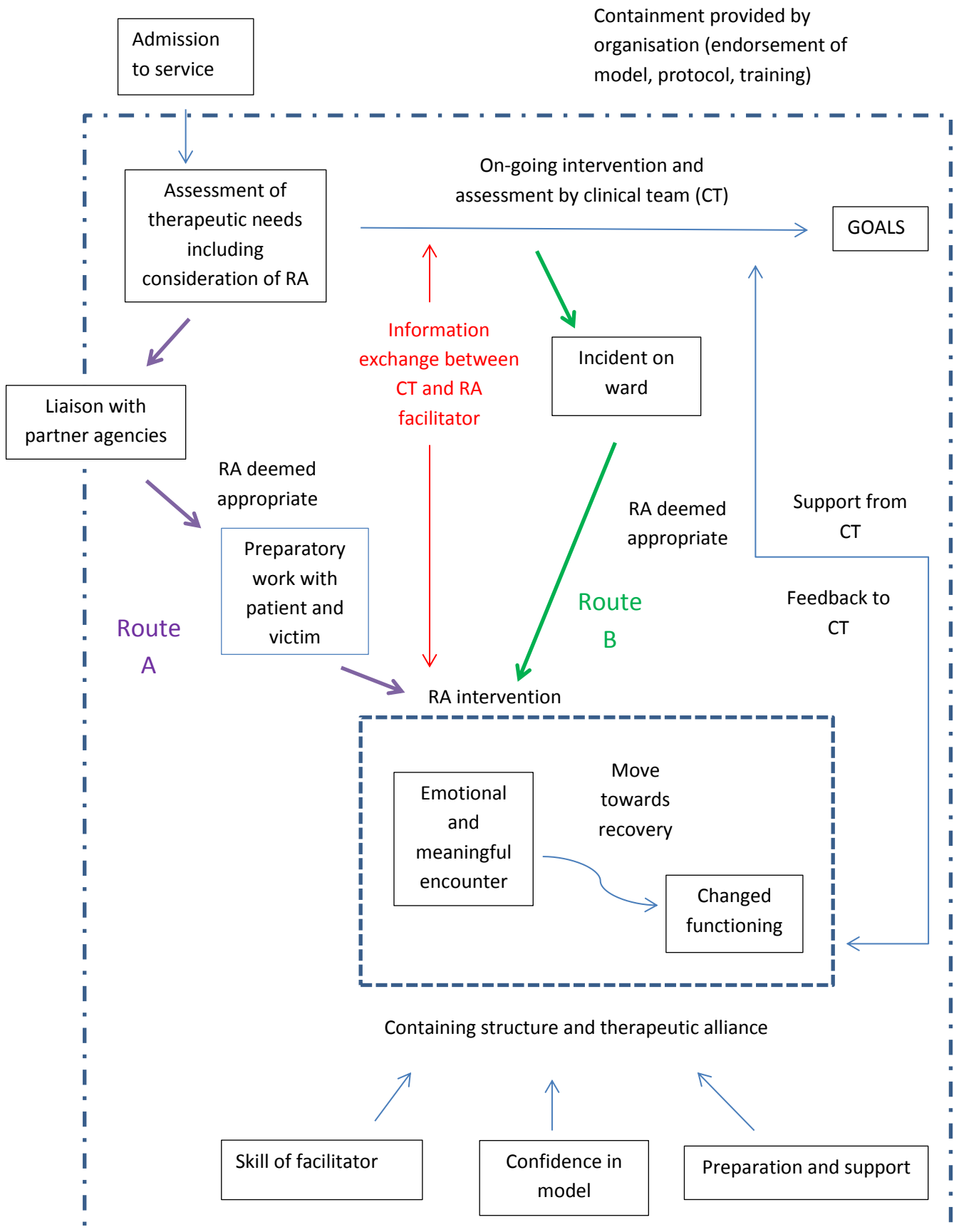
First interview done 😊 - feels great to have got started at last.

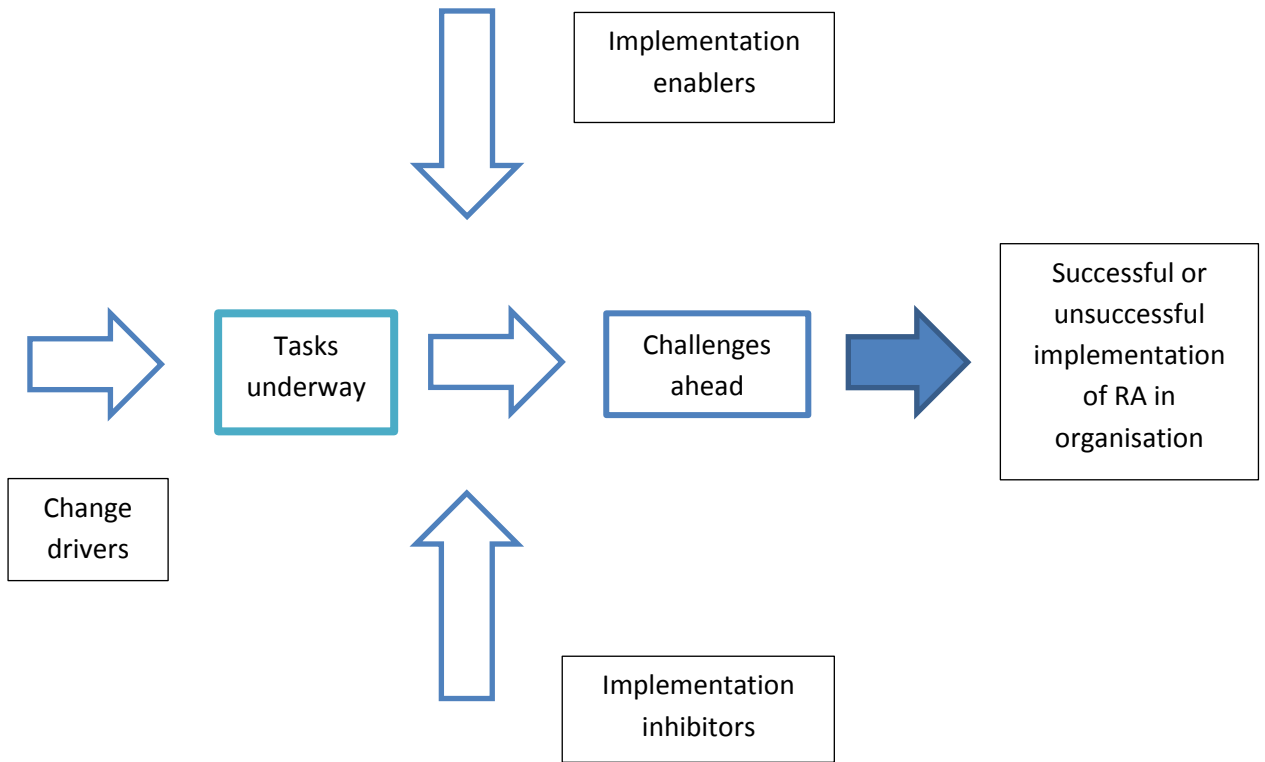
What a long process. Anxiety levels increasing as time scales getting shorter. Think I'm going to enjoy the interviews.

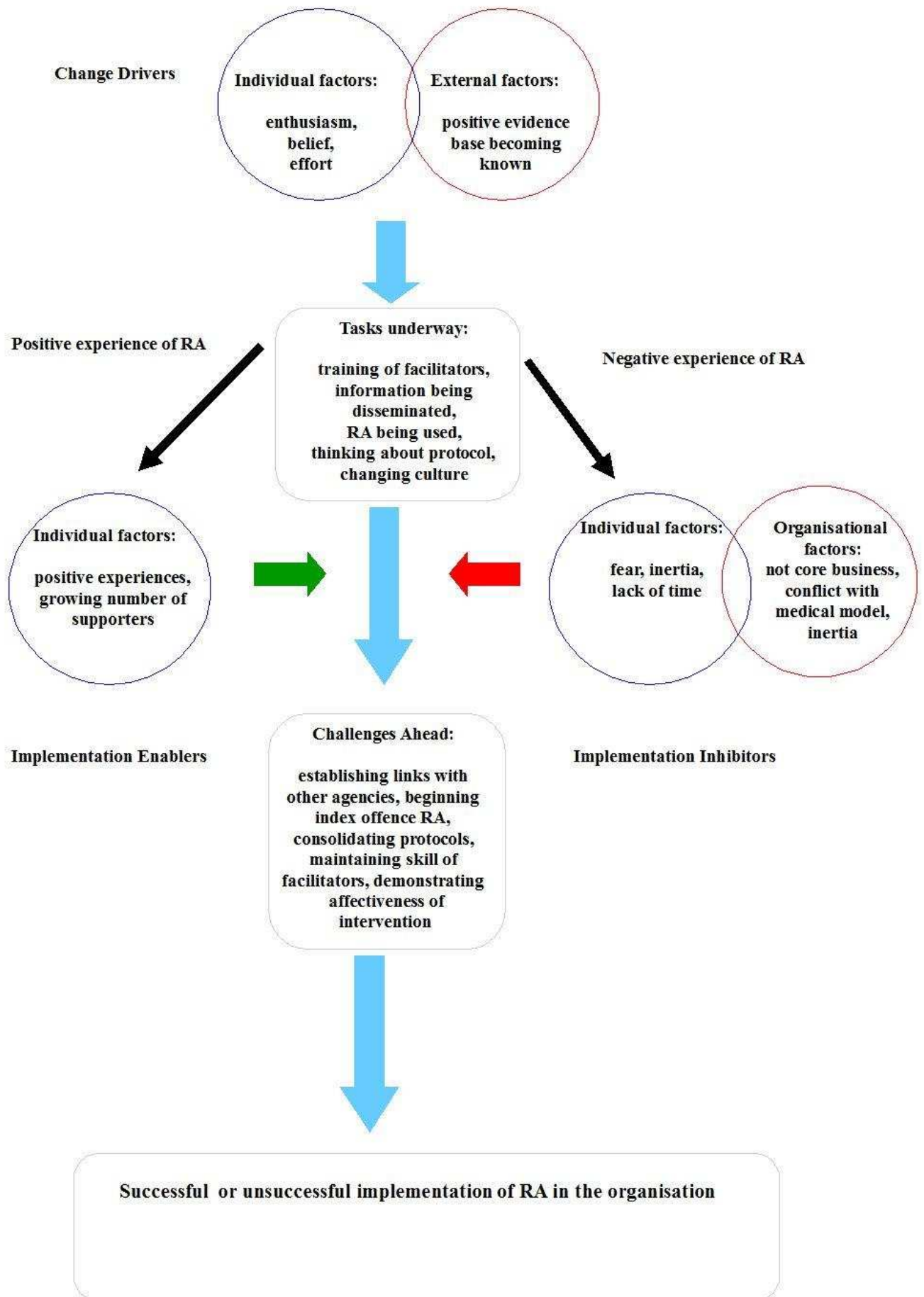
Still very few potential participants. Disappointed that there have been no formal RT conferences - research will take a different angle from originally anticipated - more staff interviews? greater focus on implementation issues?

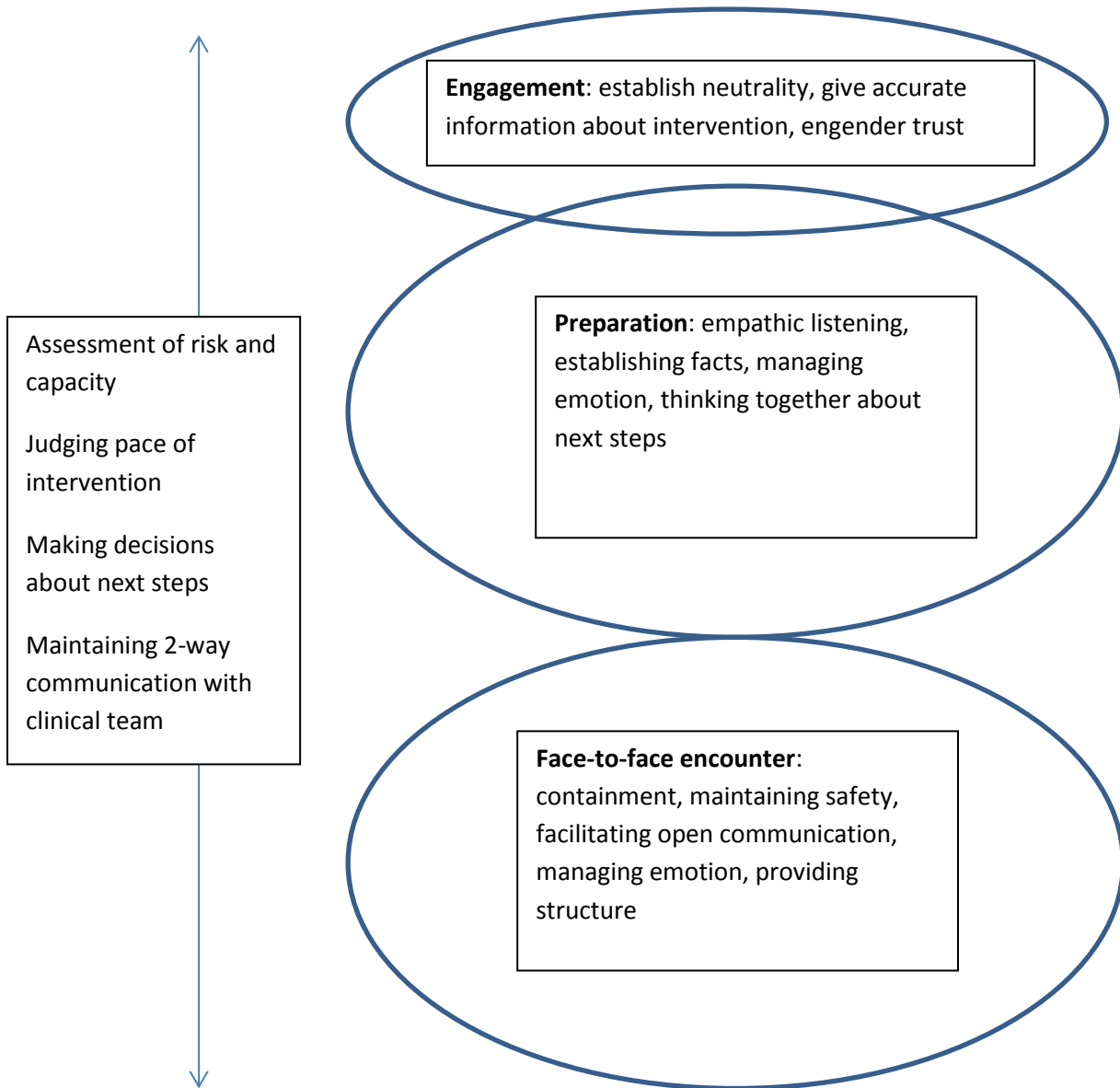
However, very rich material already - perhaps better to be going in unknown direction - results emerge from the data!

## Appendix 14 Development of grounded theory model – initial ideas









## Appendix 15

### Summary of Final Report

#### An Examination of the Implementation of Restorative Approaches in a Forensic Mental Health Setting

REC reference number: 12/LO/1044

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##### Introduction

Restorative justice is an intervention gaining worldwide recognition in criminal justice systems and other settings. There is a growing evidence base demonstrating positive outcomes in a number of domains, but to date there has been no research focussed upon the use of restorative justice in a forensic mental health setting.

##### Methodology

This study used semi-structured interviews and grounded theory analysis to examine the implementation of restorative approaches in such a setting, looking at the experience of the intervention, issues particular to this setting and the implementation process. There were ten participants including restorative justice facilitators, patients and staff victims. The aim was to develop theory regarding the psychological processes associated with the use of restorative approaches in this setting.

##### Findings

A model is developed depicting the interplay of psychological and organisational factors associated with the use of restorative justice in this setting. Results indicated that staff members and patients found the intervention to be meaningful and useful when used to address incidents occurring on the wards. Restorative approaches are found to be congruent with models of mental health and offender recovery. Processing emotions, developing thinking and coherent narrative, and immediacy are found to be key components of the intervention. The intervention was experienced as powerful and positively transformative.

Mental health problems were not experienced as a barrier to using restorative approaches given appropriate assessment and planning. The implementation process was in early stages and analysis regarding progress was offered. One key area identified was the need to maintain the skill base of the restorative facilitators if the implementation is to continue successfully. All the cases were complex and required a high level of skill from the facilitators in a number of areas, including providing a safe structure for a highly emotive encounter. An inhibitor to embracing the new approach, additional to expected resistance to change, was the fear of causing further harm. This was considered unsurprising in a high risk environment and the role of thorough assessment and preparation were strong themes. Restorative approaches fell into two broad categories either relating to index offence work or responding to incidents following admission. The former had been more difficult to progress due to the need to work closely with external agencies whereas the latter fell purely under the jurisdiction of the organisation. Whilst there were some differences in the two approaches primarily in terms of preparation time, both were viewed as requiring common components of thoughtful preparatory work and skilled facilitation. Additionally both were viewed as providing an opportunity for a transformative encounter which could contribute to the journey towards recovery for the patient. The organisation and the intervention itself were instrumental in providing a structural and supportive container to the staff, patients and processes leading to therapeutic change. The sense of containment and safety experienced by participants is given a key position in allowing for the possibility of emotional exposure and vulnerability, which in turn was viewed as key for positive transformation.

### Clinical Implications

The results from this study are viewed as a tentative endorsement of the use of restorative approaches within forensic mental health services. In such a high risk environment where the likelihood of fear and anxiety is maximised, restorative approaches could offer an alternative to defensive practice, as results indicated that it promotes a holistic encounter which mitigates against fragmenting the patient's recovery needs. The endorsement and containment by the organisation were viewed as essential in maintaining an environment conducive to the use of restorative practices.

### Further Research

Further research is recommended to expand upon the small number of participants in this study and to expand upon the areas of exploration. This study was unable to examine any restorative conferences relating to index offences and this will be an important focus for further research, as well as considering outcome data once it is generated.



## Appendix 16

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