A mixed methods evaluation of the implementation of Restorative Practice in mental health services at The Prince Charles Hospital

Summary report

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Diana Beere BTeach(Hons) PhD(GU), GCArts(UQ)

Background

Restorative practice (RP) encompasses a continuum of proactive and reactive practices designed to prevent and/or respond to conflict and incidents of harm caused by one or more persons to one or more others. When used proactively, as informal practices that are embedded into everyday life, RP can improve relationships and prevent conflict. At the other end of the continuum, RP is often termed 'restorative justice' and involves more formal processes — restorative interventions — that can be used to respond to incidents of harm. A restorative intervention is a voluntary process that is structured to create opportunities for facilitated communication between the person/s harmed and the person/s who caused the harm about what led up to the harm, its impacts, what needs to happen to repair it, and who needs to be involved in that process.

RP has been used in the youth justice system in Australia for nearly thirty years and is also well established, internationally, in the adult criminal justice system, educational facilities and workplaces. However, its use in mental health services is relatively recent and has been confined so far to a few institutions in England, The Netherlands and Canada. This is despite the fact that mental health professionals, particularly nursing staff, are vulnerable to aggression and violence from mental health consumers, which can have a range of negative effects. These include negative effects for consumers, through the breakdown of therapeutic relationships.

There is little research evidence so far to indicate the effectiveness of RP in either preventing or responding to conflict in mental health settings, nor on what might constitute good practice in implementing RP in such settings. The project to implement RP in mental health services at The Prince Charles Hospital (TPCH) is the first of its kind in Australia and presents a unique opportunity to build on the evidence base for RP in mental health settings.

About the Restorative Practice project

Implementation of RP within selected mental health services at TPCH — part of Queensland's Metro North Hospital and Health Service — commenced in December 2019, following a lengthy lead-up period of preparatory work, comprising research; cross-agency, internal and international consultation; model development and planning; and information and awareness-raising activities. Focusing initially on the Secure Mental Health Rehabilitation Unit (SMHRU), and then — from mid-2020 — extending to the Nundah and Chermside Community Mental Health (CMH) teams, the project introduced RP as both an additional option to respond to incidents of harm, including both new and historical incidents, and a means to improve relationships and prevent conflict. In the SMHRU, where incidents of harm caused by consumers to staff have previously been frequent, the project aimed to establish a restorative ward culture and ethos, and thereby potentially reduce incidents of harm, improve the therapeutic climate, and boost staff morale.

At the end of the lead-up period, interested staff from the SMHRU were invited to participate in a three-day RP skills workshops held in early December 2019. Three further workshops, held between May 2020 and June 2021, were targeted to other interested staff from the SMHRU and the Nundah and Chermside CMH teams. The workshops introduced participants to a range of practices on the RP continuum: restorative language (including both affective statements and affective questions), impromptu restorative meetings, 'restorative circles', 'fishbowls', and facilitated restorative meetings. Implementation of RP within each work area was also supported by posters, lanyard cards

and other visual resources; on-site support and coaching from the RP Lead; an RP Support Team; and group supervision and mentoring for that team from the external RP consultant who delivered the three-day workshops.

An important contextual factor to note is that the implementation of RP in TPCH mental health services coincided with the emergence of the SARS-NoV-2 virus and so the evaluation began during the early stages of what became an ongoing worldwide COVID-19 pandemic.

Evaluation methods

The evaluation used a mixed methods design to answer six key evaluation questions (KEQs), as follows:

KEQ 1: How well were TPCH mental health services prepared for the implementation of RP?

KEQ 2: What problems were encountered during the implementation of RP in TPCH mental health services and how were they overcome?

KEQ 3: What aspects of the RP model or its implementation worked well?

KEQ 4: What improvements could be made to the model or its implementation to achieve better outcomes?

KEQ 5: What is needed to ensure the sustainability of RP in TPCH mental health services?

KEQ 6: To what extent has the use of RP within TPCH mental health services achieved benefits for:

a. people who have been caused harm by TPCH mental health service consumers or staff
b. those who have caused harm
c. other stakeholders, including TPCH SMHRU community as a whole?

The first five KEQs were addressed through a 17-month process evaluation, which analysed data collected primarily through two rounds of semi-structured interviews with project stakeholders. Additional data sources for this component included feedback sheets completed by participants in the three-day RP skills workshops, a series of three structured online staff surveys, and meeting papers and minutes of the project Steering Committee and the RP Support Teams.

A two-year outcomes evaluation addressed the three parts of KEQ 6, focusing primarily on outcomes in TPCH SMHRU. The data analysed for this component of the evaluation were collected via:

- two surveys of social climate within the SMHRU
- the three online staff surveys mentioned above
- post-meeting feedback sheets completed by participants in facilitated restorative meetings
- six-month follow-up telephone interviews with participants in facilitated restorative meetings
- semi-structured interviews with TPCH SMHRU staff and consumers.

Metro North Mental Health supplied additional data for the outcomes component of the evaluation. They included de-identified data on referrals to facilitated restorative meetings and the outcomes of these referrals, as well as a variety of de-identified administrative data on both TPCH SMHRU and — for comparison purposes — the Caboolture Hospital SMHRU.

What the evaluation found

KEQ 1: How well were TPCH mental health services prepared for the implementation of RP?

Feedback on all four of the three-day RP skills workshops was overwhelmingly positive. The majority of participants in each workshop who completed a feedback form viewed the training as relevant to their work, believed that it would make a difference to the way they did their job and expressed confidence about using RP skills in their work areas. That said, CMH participants tended to be less sure about the relevance of the workshop training to their work and many used the open-ended questions on the feedback form to comment on the need for the training to be better tailored to the work of CMH teams. Such sentiments were echoed by several of those online survey participants who responded to an open-ended invitation for additional comments.

The usefulness of the training staff had received, if any, in preparing them for the implementation of RP and for using RP skills in their work areas was the subject of several questions in the three online staff surveys, and again the responses across all three surveys were mostly positive. The online surveys also asked staff who had completed at least some training (a half-day awareness session and/or a three-day workshop) whether they would have preferred to have had more, less or about the same amount of training. Overall, the results suggest that regardless of the amount of training they had received, about half of those staff who had done some training were satisfied that it was about the right amount. However, several respondents to each survey would have preferred more training, while a few would have liked less. Most of those who had received no training would have liked to have had some.

Participants in the two rounds of stakeholder interviews generally took the view that they had been well, or well enough, prepared for the implementation of RP in their work areas, and few could suggest any ways in which they might have been better prepared. However, a good deal of ambivalence towards the RP project had developed by the time of the first three-day skills workshop in December 2019. Interview participants attributed the more negative attitudes that developed during the lead-up to implementation to a number of factors:

- a lack of communication and consultation by the executive team about the RP project and about why the three work areas had been chosen, rather than others, to participate in it
- the focus in the half-day awareness sessions on facilitated restorative meetings rather than the full continuum of restorative practices
- staff perceptions that most SMHRU consumers and many CMH consumers would be incapable of participating in facilitated restorative meetings
- a workplace culture, particularly in the SMHRU, that was not particularly compatible with RP.

KEQ 2: What problems were encountered during the implementation of RP in TPCH mental health services and how were they overcome?

The RP project encountered many challenges. Not the least of these was the COVID-19 pandemic, which interfered with the workshop training schedule as well as adding to the workloads of the participating mental health services, particularly the Chermside CMH team. Lockdowns during the pandemic also prevented the RP Lead from providing the Chermside CMH team with on-site support to help them understand the relevance of RP to their everyday work and to identify opportunities to use the skills. This was particularly problematic given that the Chermside CMH team was a key source of negativity towards the project.

Negative attitudes towards the RP project remained a significant barrier to implementation for some time, to the extent that the Chermside CMH team eventually opted out of the project. However, as more staff completed the three-day skills workshops and the RP Lead continued providing on-site support and coaching, doubts among SMHRU and Nundah CMH staff about the relevance of RP to their work fell away, along with a common misconception that RP is primarily about restorative meetings.

Culture change has also been a significant challenge for the RP project, particularly in the SMHRU, where long-term consumers tend to have become institutionalised. Often they are on Forensic Orders under the *Mental Health Act 2016* and subject to review by the Mental Health Review Tribunal, and given the need to manage risk, SMHRU staff are used to taking a highly authoritarian role. However, culture change is also a problem for CMH teams within a public mental health system that, according to interview participants, has long been oriented towards doing things to and for consumers, rather than with them. This orientation does not align well with RP.

Interview participants identified a range of other challenges encountered during the implementation of RP, including the following:

- lack of high-level leadership, communication and consultation
- the change of Nurse Unit Manager in the SMHRU just before implementation commenced
- lack of time, which has been a problem for both the 0.7 FTE RP Lead and busy mental health staff struggling with competing priorities
- change fatigue, particularly among long-term staff
- how best to train staff in future, including new staff coming into the participating teams
- managing scope creep, as interest in the project has grown among other TPCH mental health services
- the difficulties experienced by the RP Support Team in the SMHRU — a shift-work environment — in fulfilling its leadership and support role
- a perception among some Nundah CMH staff that supporting consumers to attend formal restorative meetings might be outside their scope of practice
- a lack of clarity among Victim Support Coordinators about their role of providing support to a person who is engaging in a formal restorative meeting as the person harmed.

KEQ 3: What aspects of the RP model or its implementation worked well?

Participants in both rounds of interviews often identified the model in general as something that was working well. Some talked about its compatibility with not only the rehabilitation focus of the SMHRU, but also the mental health recovery model and trauma-informed care. Others commented that the model offers something for everyone and several perceived it to be useful in relationships with both consumers and colleagues.

Specific aspects of the model were also identified as working well. These included restorative circles, which had become embedded in the daily routine of the SMHRU, where they were often being run by the consumers themselves. Both SMHRU and CMH staff were also enthusiastic about using circles with their colleagues — for example, in team meetings, shift handovers and debriefing after incidents. In addition, CMH staff were finding fishbowls useful in case reviews.

Interview participants had also found that:

- using restorative language (affective statements and questions) was helping to resolve conflict and maintain therapeutic relationships
- the social discipline window was useful in encouraging reflective practice and as a teaching tool
- explicit use of the social discipline window provided a common language for staff and consumers to talk about and reflect on how they engage with each other
- the visual resources, including posters and lanyard cards, were working well as reminders and prompts.

When asked about aspects of the model's implementation that were working well, interview participants most commonly mentioned the three-day skills workshops and the on-site support provided by the RP Lead. However, they also commented positively on:

- the fact that RP had been introduced as a voluntary option
- the external RP trainer's visits to the SMHRU to talk with consumers about RP
- collaboration between staff and consumers in the design of visual resources
- the commitment of the project team
- the involvement of TPCH Mental Health staff outside the SMHRU and the CMH teams
- regular RP Support Team meetings
- opportunities for the project team to share ideas and resources with international colleagues.

KEQ 4: What improvements could be made to the model or its implementation to achieve better outcomes?

None of the stakeholder interviews elicited any suggestions for improvements to the RP model itself, and few participants, other than the RP Lead, offered ideas for improvements to its implementation from this point onwards. The most common suggestions were for things that, with the benefit of hindsight, could perhaps have been done better or differently in the early days of the RP project. These included:

- omitting the half-day RP awareness sessions
- making the workshop training more relevant to mental health settings
- concluding the workshop training with a planning session
- more consultation and communication with staff in the teams selected to participate in the RP project
- rolling out the training within a shorter timeframe
- focusing on one team at a time
- introducing RP to the consultants and the team leaders at the same time
- more active involvement and leadership from the executive team.

The RP Lead described a variety of planned or wished-for improvements to both strengthen the implementation of RP in the SMHRU and the Nundah CMH team and help ensure its sustainability.

KEQ 5: What is needed to ensure the sustainability of RP in TPCH mental health services?

Many interview participants believed that certain elements of RP — such as the circles during morning meetings in the SMHRU and the fishbowls during the CMH teams' case reviews — were already embedded into everyday practice and would continue indefinitely as long as leadership support, staffing and visual reminders about RP remained constant. However, most participants believed the RP project had not yet reached a point where it would be sustainable without the involvement of someone (such as the RP Lead) whose job it was to continue championing the use of RP. While some believed RP should be internally driven within each team, others saw this as impractical in the face of high existing workloads and competing priorities.

Most participants saw ongoing access to high quality training for new staff as necessary to ensure the sustainability of RP in the teams where it has been introduced. Many also suggested regular (annual or biennial) refresher training was needed. A few people suggested training in RP should be mandatory for new staff — a suggestion that might be viewed as incompatible with the principle that RP should be voluntary. It was proposed, however, that the training could be mandatory even if the use of RP was not, and that for the SMHRU to achieve the goal of becoming a 'restorative ward', most if not all SMHRU staff would need to have RP skills in their toolkit. The same sort of thinking was apparently behind suggestions that, to support sustainability, something about RP could be incorporated into induction sessions, supervision sessions, performance and development plans, and policies and guidelines.

The RP Lead had some specific ideas for training resources, including an online course that could be completed in small chunks, thus reducing the amount of time spent in face-to-face training. Such resources come at a cost, however, so their development would depend on the availability of further funding.

Finally, several interview participants argued that, for RP to be sustainable in TPCH mental health services over time, the executive team needed to become more actively involved in its implementation.

KEQ 6a: To what extent has the use of RP in TPCH mental health services achieved benefits for people who have been caused harm by TPCH mental health service consumers or staff?

Because of the small numbers of people involved in facilitated restorative meetings during the study period, the data on the benefits that RP has achieved for people who have been caused harm by TPCH mental health consumers or staff are limited. However, they are unequivocally positive. All three of the restorative meeting participants who identified as having been or having felt harmed indicated agreement or strong agreement with all the statements on their post-meeting questionnaires — all of which were positively worded.

In particular, all three strongly agreed that the meeting was valuable for them personally. In a six-month follow-up interview, one of these people gave strongly positive responses, and emphasised their high level of satisfaction with both the meeting process and its outcomes. They strongly believed that participating in the restorative meeting had helped them recover from the harm that was done to them.

Another of the three people who had been or felt harmed also participated, several months later, in the one-to-one stakeholder interviews. During their interview, they expressed the view that, had it not been for the restorative meeting, they probably would have left their job. However, the meeting was 'amazing' and they now work comfortably with the person with whom they had been in conflict.

KEQ 6b: To what extent has the use of RP in TPCH mental health services achieved benefits for consumers or staff who have caused harm to others?

The data with which to answer this question were even more limited, but again they are consistent and indicate that the use of RP can have benefits for consumers or staff who cause harm to others. A consumer who caused harm reported finding it personally valuable to have participated in a facilitated restorative meeting and would recommend the process to others who have caused harm. They also believed that the experience would help them to avoid repeating the behaviour that caused the harm.

During the stakeholder interviews, a staff member who had been the subject of a complaint by a consumer reported that they had benefited from the restorative meeting process and believed it had also benefited the consumer involved.

KEQ 6c: To what extent has the use of RP in TPCH mental health services achieved benefits for other stakeholders, including the SMHRU community as a whole?

While the results of the surveys of social climate tend to suggest that the implementation of RP in TPCH SMHRU had negative effects, there are several reasons why these results should be interpreted with caution. Most importantly, they are contradicted by the overwhelmingly positive data collected from other sources, which included the three online staff surveys, the post-meeting questionnaires and the one-to-one stakeholder interviews, as well the Metro North Mental Health administrative data.

Analysis of the latter data found that both the Caboolture and TPCH SMHRUs experienced an improvement in the rate of seclusion events per 1,000 bed days during the period March 2021 to February 2022 — when the RP project was well underway at TPCH SMHRU — compared with the period March 2018 to February 2019, before the RP project commenced. However, while the improvement was statistically significant at TPCH SMHRU, at the Caboolture SMHRU it was not. The improvement in the number of seclusion events at TPCH SMHRU during the later period, compared with the earlier period, was also statistically significant. However, while the trend in the average length of seclusion events at TPCH SMHRU also improved, one particularly lengthy seclusion event during that period meant that the improvement overall was not statistically significant.

The majority of respondents to each of the online staff surveys who had either used RP in situations where someone had caused or threatened physical harm to another person or had observed it being used in such situations reported that it had been moderately or very useful. Additionally, a clear majority of respondents to each survey felt that RP had either already benefited their work area or would do so over time.

The one-to-one interviews revealed a wide range of ways in which SMHRU consumers, SMHRU staff and in-reach staff, and the SMHRU community as a whole had benefited from the introduction of RP. For example, almost all interview participants — including most of the consumer participants — commented enthusiastically on the benefits of using circles as a regular part of the morning meetings in the SMHRU. Many had observed consumers engaging more positively with each other as well as with staff. SMHRU staff members had also found circle discussions valuable in helping them manage day-to-day issues on the ward — including issues arising from lockdowns during the COVID-19 pandemic.

Many SMHRU staff also reported finding RP useful as a framework to guide their everyday interactions with consumers and/or as a teaching tool for new staff. Some reported that it had changed the way they do things for the better. Several noted the compatibility of RP with the relatively recent rehabilitative role of the SMHRU. Most acknowledged that the restorative questions are not effective with all SMHRU consumers, but some believed that using the questions helped them to maintain objectivity when dealing with conflict between consumers.

When asked about differences, if any, they thought the introduction of RP had made to the SMHRU as a whole, almost all interview participants who were familiar with the SMHRU before the project commenced were able to identify changes they had observed since that time. Among other changes, they talked about improvements to the culture, better therapeutic relationships, and a decline in violence. While some interview participants were uncertain whether RP had been the sole cause of some of the changes — noting that there had been changes of staff as well, and that some of the improvements may have happened anyway — they acknowledged that RP was a likely contributing factor.

Conclusions

In the face of considerable challenges, the implementation of RP in both TPCH SMHRU and the Nundah CMH team must be regarded as a significant achievement, even given most stakeholders' doubts about its sustainability at this point. The evaluation gathered considerable evidence that the use of RP in TPCH mental health services had generated a variety of benefits. Those who benefited included not only people who had been harmed by TPCH mental health service consumers or staff, but also the people who had caused the harm, together with a range of other stakeholders, including the SMHRU community as a whole. Importantly, evaluation participants almost unanimously believed there was no downside to introducing RP.

However, this evaluation also identified some potential improvements that may strengthen the sustainability of RP in the SMHRU and the Nundah CMH team. Most of them, such as those that involve the development of training and other resources — would require substantial additional funding. However others, such as the more active involvement of the executive leadership team, could be implemented with minimal resources while yielding multiple benefits.

The evaluation findings also offer some learnings that could be considered in any further roll-out of RP to other mental health services. For example, they highlight the value of co-locating an RP Lead (project coordinator) within the teams where RP is being implemented, and of persevering with this arrangement for at least several months. However, co-location needs to be managed carefully, and to be actively supported by team leaders.

This support could be fostered by not only enabling team leaders to participate in the RP training ahead of their teams, but through consultation with them well before that. Follow-up support immediately after their training would also be beneficial, to help them to become thought leaders and perhaps coach them through a 'soft' implementation of regular team activities such as circles and fishbowls, prior to the rest of the team being trained in RP skills and practices.

Most staff in the SMHRU and the two CMH teams felt that they had been well enough prepared for the implementation of RP in their work areas. In hindsight, however, it seems likely that a stronger

focus at the outset on the ways in which RP could be used proactively to build a restorative ward and team culture, and how this might support consumers' recovery journeys, would have helped to overcome some of the barriers to its implementation — and perhaps prevented the Chermside CMH team's withdrawal from the project. Such an approach might have enabled mental health staff to more easily recognise the relevance of RP to their work and minimised the likelihood of them perceiving a formal restorative meeting to be the desired end point of all restorative practices. Moreover, based on stakeholders' views on aspects of the RP model that were working well, it seems likely that most of the benefits to be gained from the use of RP in TPCH mental health services will result from the everyday use of proactive RP skills and processes.

With this in mind, for any future rollouts, it may be worth considering making RP training compulsory, as a few stakeholders suggested. While participation in restorative meetings should certainly be voluntary, it is not clear from the literature reviewed for this evaluation that training in RP skills need necessarily be voluntary. Indeed, it is hard to envisage how a secure mental health facility such as the SMHRU could become a 'restorative ward' and maintain a restorative culture over time unless all staff have RP skills as part of their toolkit, even if they choose not to use them.