Workshop:

Ready for Restorative: Preparation, and Implementation in a Mental health Context

Catriona Harwood, Social Worker, Restorative Practice Lead (on secondment)

Metro North Health | Queensland Government

Acknowledgement of Country

Metro North Allied Health would like to acknowledge the Tuurbal, Jagara and Yuggera Ugarapul peoples as the Traditional and Cultural Custodians on the lands in which we meet today here in Meanjin, Brisbane, and pay respects to Elders past, present to emerging.

Also wish to acknowledge the Wurundjeri Woi-wurrung and Bunurong Boon Wurrung Peoples of the Eastern Kulin on which this conference is held.

Aboriginal and Torres Strait Islander communities and other First Nations people have a long history of using Restorative approaches to respond to conflict and harm. Concepts of responsibility and accountability to community, relationship repair and family and community decision making are part of First Nations processes used to resolve conflict and respond to incidents of harm.

Recognition of Lived Experience

We recognise the lived and living experience of people living with mental illness, problematic alcohol and other drug use, as well as those impacted by suicide and trauma, their families, carers and support people. We respect and value their opinions and their input into service delivery and change

WORKSHOP OUTLINE

1. Check in
2. Background of Restorative Practice (RP) and rationale in mental health services at The Prince Charles Hospital (TPCH), Brisbane, Australia
3. Model of Restorative Practice Framework in mental health – the window and continuum
4. Context assessment and evaluation
5. Activity – Context assessments
6. Results and Learnings from our approach
7. Activity – Social Discipline Shuffle
8. Checkout

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But first a question to ponder...

What would it mean to you, to your colleagues, your consumers and their families, to have a healthcare system that valued relationships over all else, that was accountable, fair and conflict competent when responding to and preventing harm in our setting?

2. Background of Restorative Practice at The Prince Charles Hospital

Incidents of harm in healthcare are a concern for healthcare staff, consumers, carers, leaders

- Current systemic responses to harm can harm further
- Opportunities to use restorative approaches demonstrated from Restorative Practice Stage One (evaluation 2022)

Using a relational approach

- Those most directly impacted invited to participate
- Working in the WITH box
- Alignment with trauma informed and recovery focused approach

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Context of Restorative Practice in Mental Health

Patients cannot take responsibility for the past, but when they have the capacity to recognise the harm they have caused they can take ownership of the actions and take responsibility for the harm going forward. It can limit their progress when they do not work through taking responsibility for their actions

Dr Gerard Drennan, Head of Psychology and Psychotherapy, Lead Psychologist, Forensic and Offender Health Pathway, South London and Maudsley NHS Foundation Trust

Person harmed at the centre

- Danger of making assumptions
- If the person harmed is a consumer think about the environment
- How can we support someone if systemic harm played a part?
- Are others impacted (e.g. family, staff, others, organisational)?
- Supports available

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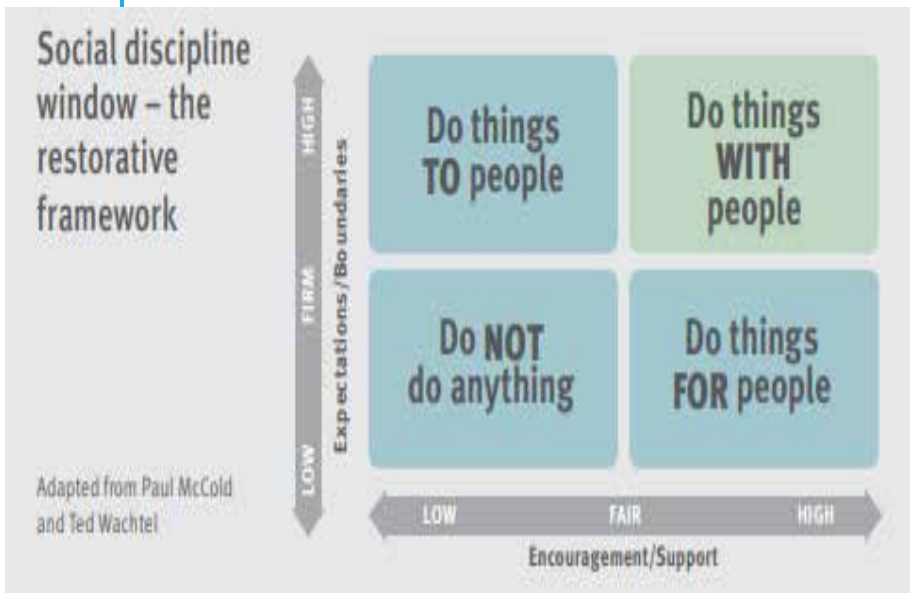
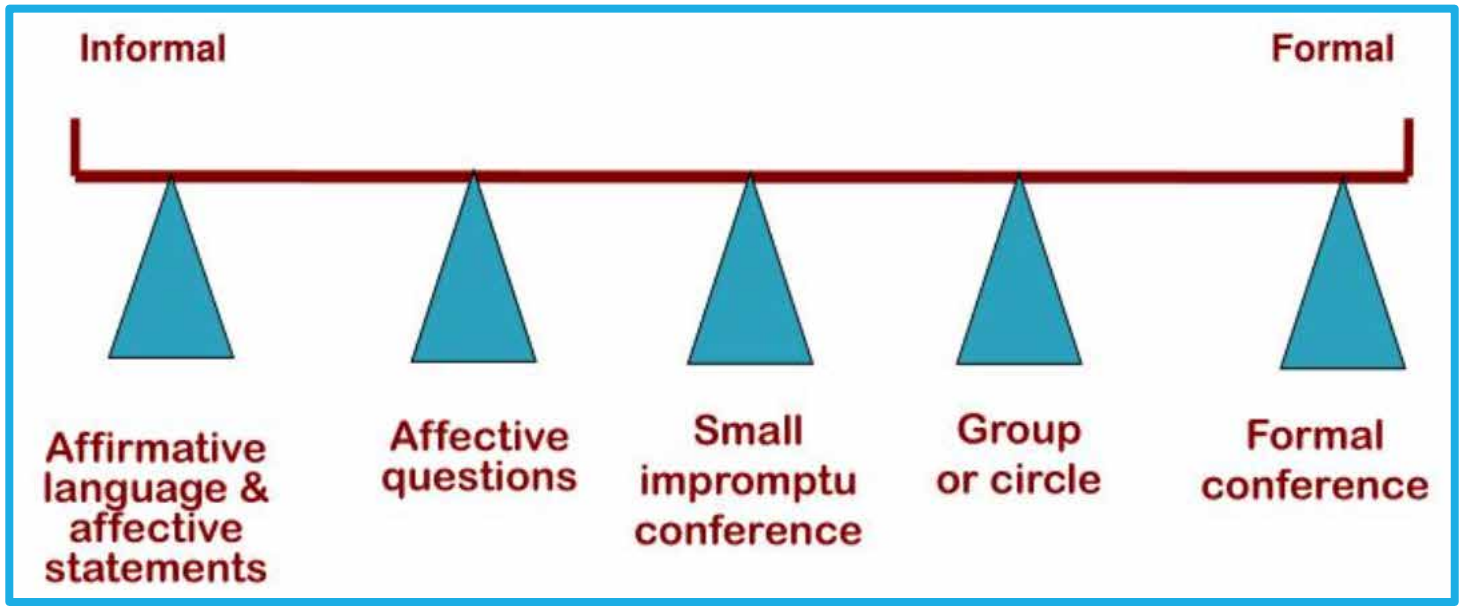
3. RESTORATIVE FRAMEWORK





Social Discipline Window and Restorative Continuum adapted from International Institute of Restorative Practice, Wachtel and McCold (2001)

Aims of Restorative Practice in mental health services

The aims of implementing Restorative Practice within mental health services at The Prince Charles Hospital are:

- A voice for all (consumers, staff, family/supports) proactively to address harm and influence behaviour change
- Accountability for when harm occurs
- A culture where restorative language is known, used, expected and understood by all (e.g. understanding who is impacted, their needs, using Restorative Dialogue, Restorative Circles, Restorative Meetings, and the processes and rationale behind them)
- Reinforcing the importance of relationship repair for all within the healthcare setting

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WHY IMPLEMENTATION SCIENCE? - EVIDENCE PRACTICE GAP

"Healthcare systems are stuck in a rut. Despite countless reform efforts, performance remains substantially the same: ~60% of care is in line with evidence-based guidelines; ~30% is wasteful or low value, and ~10% is harmful. These numbers have not changed for decades."

Prof Jeffrey Braithwaite, Prof Paul Glasziou, and Prof Johanna Westbrook

Tackling the 60:30:10 Challenge - Health System Sustainability. (2020). Retrieved 2 June 2022, from https://healthsystemsustainability.com.au/tackling-the-603010-challenge/

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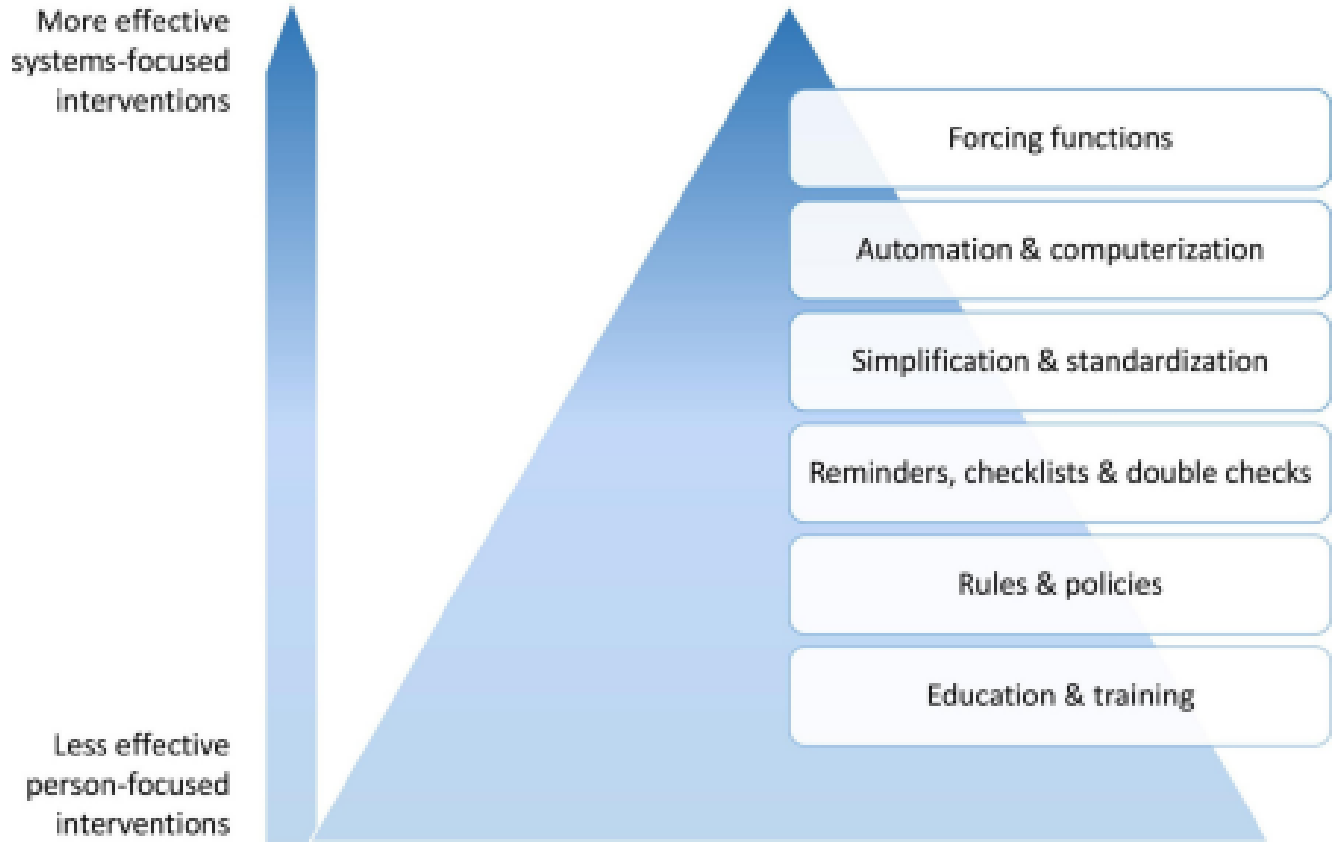
EVIDENCE-BASED STRATEGIES



Clinical audit does not work, is quality improvement any better? (researchgate.net)

Education as a low-value improvement intervention: often necessary but rarely sufficient (bmj.com) (**doesn't mean education's not effective, just not biggest bang for buck**)

Figure 1 The hierarchy of intervention effectiveness (Adapted from the Institute for Safe Medication Practices[25] and Patientsafe Implementing effective safety solutions.[43]

4. Context Assessment and Evaluation(RPMH2)

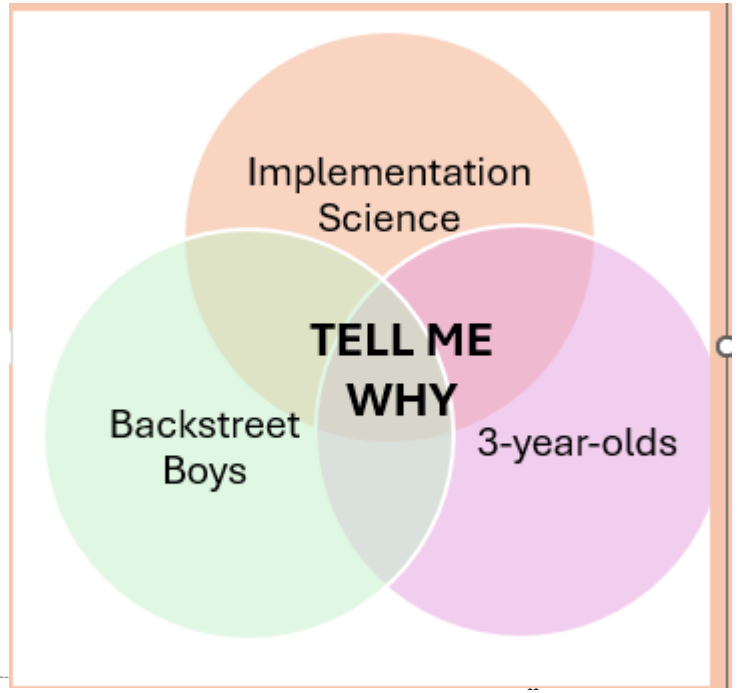
Part 1: Establishing a context mapping process

To support further implementation of restorative approaches at MNMH by engaging with participants contextually using an implementations science approach

Part 2: Refining the Restorative Practice Implementation and Learning Strategy

To adapt the restorative learning package to context

To restorative capacity build with teams by facilitating restorative learning opportunities for all levels of staff, including lived experience workforce, then evaluate



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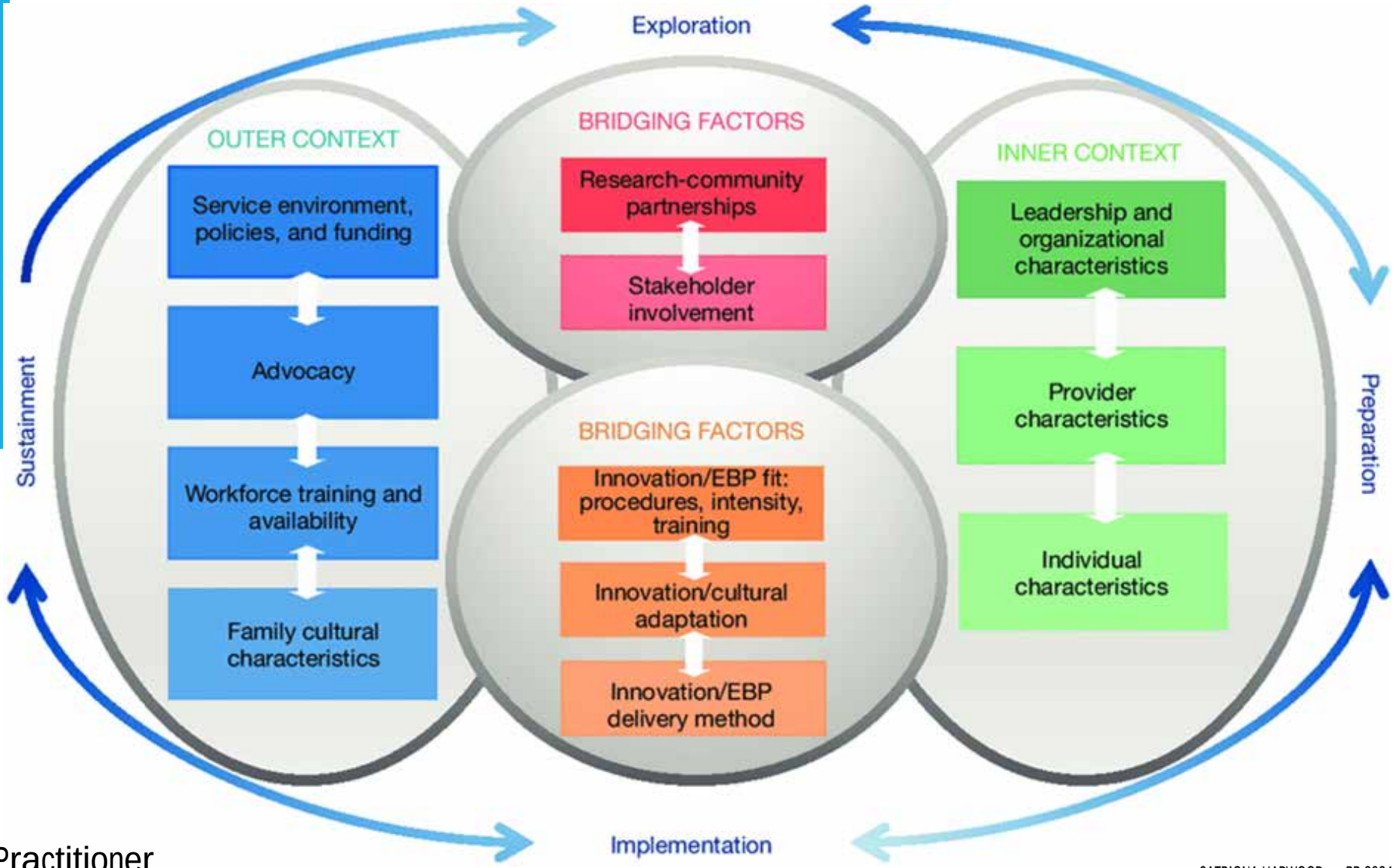
Methodology - EPIS framework

Understanding context to support implementation

Aarons, Hurlburt, and Horwitz (2010)



EPIS framework

EPIS Stage	Methods	Time
EXPLORATION	Executive, Restorative team, and Invited team leadership (or proxy) engagement, summary of the literature and priority review, context tool development, clinician/expert feedback	Dec 22-Feb 23
PREPARATION	Further team engagement through MDT's Assessing and refining strategy **Context Planning Tool Pilot with (5 teams) Assessing the context map (CAI score, attitudes to harm, priorities, - **plus focus group (4 teams)	March – May 23
IMPLEMENTATION	Adaptation restorative workshop to 2 days Delivery/facilitation of workshops **Evaluation of pre-post workshop data	May – August 23
SUSTAINMENT	Ongoing onsite mentoring and support team development **3-month post workshop survey Mixed method analysis of final results	August – Nov 23

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CONTEXT MATTERS…

Contextual factors, not treatment effectiveness, play a dominating role in whether and how quickly a clinical innovation will become widely used.

BUT Context definition not consistent (Rogers et al; 2020)– but broadly = context can encompass culture, leadership, evaluation e.g. CAI tool

5. CONTEXT ASSESSMENTS – SLIDO QS AND DISCUSSION

Responding to harm and conflict is a problem in my setting

My setting/team prioritises evidence based practice in our client work

Speaking up about mistakes and reflective learning is common practice in my setting

My setting/team has leadership that role models collaborative practice

I am confident in facilitating a restorative conversation following harm

I would value further learning opportunities to be more conflict competent in my setting

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Speaking up about mistakes and reflective learning is common practice in my setting

ⓘ Start presenting to display the poll results on this slide.

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My setting/team prioritises evidence based practice in our client work

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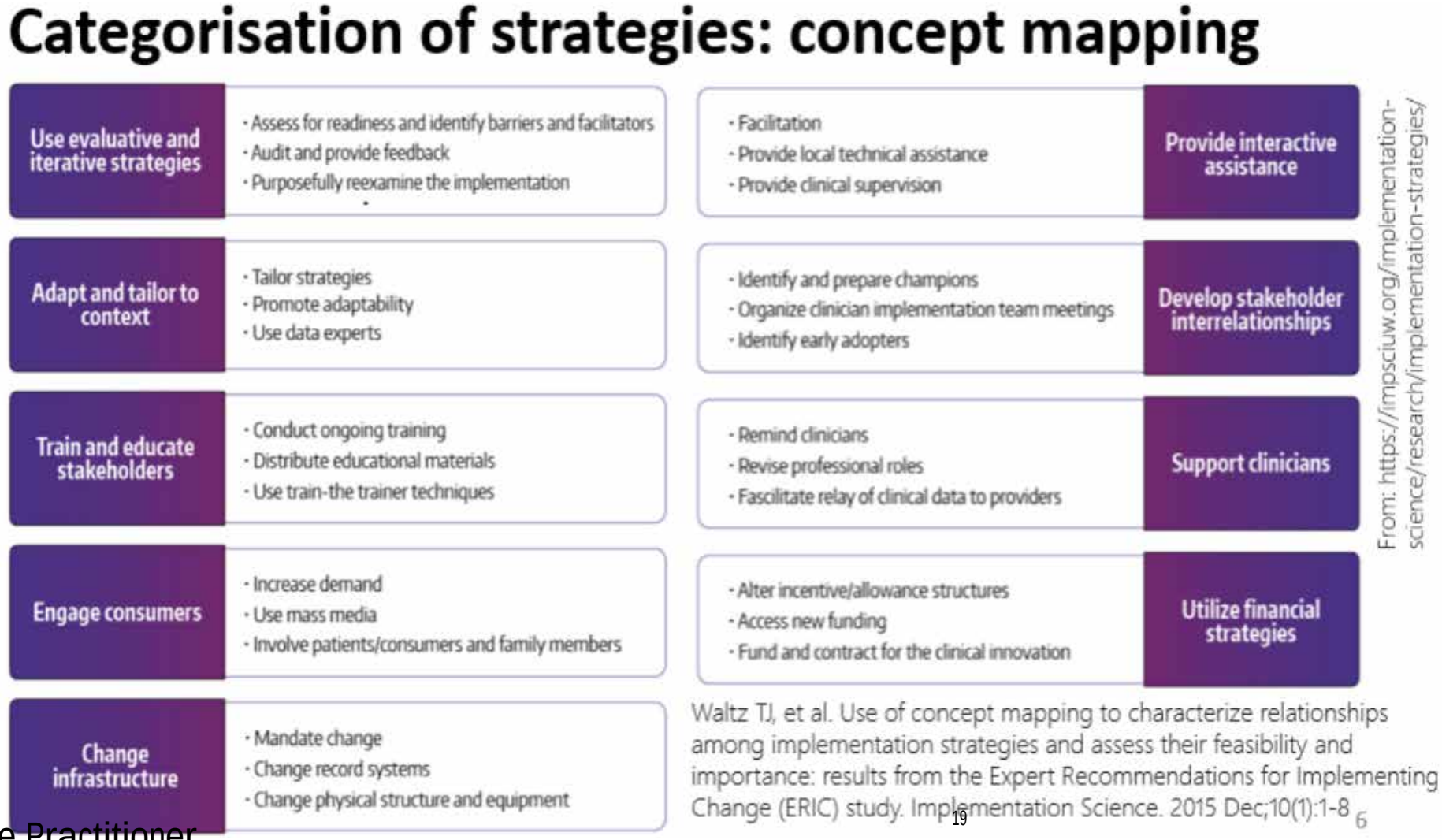
Please download and install the Slido app on all computers you use

Responding to harm and conflict is a problem in my setting

ⓘ Start presenting to display the poll results on this slide.

IMPLEMENTATION STRATEGIES

The Expert Recommendations for Implementation Change (ERIC) study categorises the implementation and discrete implementation strategies (Powell et al; 2015), and supported selected implementation interventions based on context. The ERIC strategies were useful to consider following the context assessment process.



Use Evaluative and Iterative Strategies	
Assess for readiness & identify barriers and facilitators	Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort.
Audit and provide feedback	Collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior.
Conduct cyclical small tests of change	Implement changes in a cyclical fashion using small tests of change before taking changes system wide. Results of the tests of change are studied for insights on how to do better. This process continues serially over time and refinement is added with each cycle.
Conduct local needs assessment	Collect and analyze data related to the need for the innovation.
Develop a formal implementation blueprint	Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include: 1) aim/purpose of the implementation; 2) scope of the change (e.g., what organizational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation effort over time.
Develop and implement tools for quality monitoring	Develop, test, and introduce into quality-monitoring systems the right input—the appropriate language, protocols, algorithms, standards, and measures (of processes, patient/consumer outcomes, and implementation outcomes) that are often specific to the innovation being implemented.
Develop and organize quality monitoring systems	Develop and organize systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement.
Obtain and use patient/consumer and family feedback	Develop strategies to increase patient/consumer and family feedback on the implementation effort.
Purposefully reexamine the implementation	Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care.
Stage implementation scale up	Phase implementation efforts by starting with small pilots or demonstration projects and gradually moving to system wide rollout.
Provide Interactive Assistance	
Centralize technical assistance	Develop and use a centra
Facilitation	A process of interactive p
Provide clinical supervision	Provide clinicians with or
Provide local technical assistance	Develop and use a syster

Support Clinicians	
Create new clinical teams	Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered or more successful.
Develop resource-sharing agreements	Develop partnerships with organizations that have resources needed to implement the innovation.
Facilitate relay of clinical data to providers	Provide as close to real-time data as possible about key measures of process/outcomes using integrated modes/channels of communication in a way that promotes use of the targeted innovation.
Remind clinicians	Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation.
Revise professional roles	Shift and revise roles among professionals who provide care and redesign job characteristics.
Engage Consumers	
Increase demand	Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation.
Intervene with patients/consumers to enhance uptake and adherence	Develop strategies with patients to encourage and problem solve around adherence.
Involve patients/consumers and family members	Engage or include patients/consumers and families in the implementation effort.
Prepare patients/consumers to be active participants	Prepare patients/consumers to be active in their care, to ask questions, and specifically to inquire about care guidelines, the evidence behind clinical decisions, or about available evidence-supported treatments.
Use mass media	Use media to reach large numbers of people to spread the word about the clinical innovation.

esearch | Open access | Published: 12 February 2015

A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project

yron J Powell, Thomas J Waltz, Matthew J Chinman, Laura J Damschroder, Jeffrey L Smith, Monica M Matthieu, Enola K Proctor & JoAnn E Kirchner

mplementation Science 10, Article number: 21 (2015) | Cite this article

6. Results – from 4 assessment points

Context assessment (survey 1, focus group, and 4)

- Strong indication from all teams of cultural readiness for change, and enthusiasm for restorative learning
- The effect of Timepoint 1-2 was non-significant (all above 70% overall scores total when measuring team cohesion in Leadership, Evaluation and Culture) from CAI tool

Priority areas (survey 1)

- highlights workforce capability, strengthening service capacity, and responding to crisis
- Workforce and workload consistent theme of challenge to safety and service delivery

Attitudes to harm (survey 1 and 4)

- Regarding attitudes to harm, incident of harm being a problem of recognition we noted a slight increase from timepoint 1 to 2, not necessarily because there were more incidents of harm, but because we are often desensitised (similar findings in YJ studies), slight increase in workplace satisfaction (not statistically significant)

Workshops pre/post learning (survey 2 and 3)

- indicated significant restorative use confidence increase, and understanding of potential benefits of RP within setting from the Restorative Practice Implementation scale over 3 timepoints (validated and consistent)

Restorative alignment (survey 1 and 4)

teams would value responses such as more reflective practice and responding to incidents more proactively that aligned with more restorative approaches to enhance safety.

A lack of confidence regarding security personnel response/access, more so for the teams in a community setting

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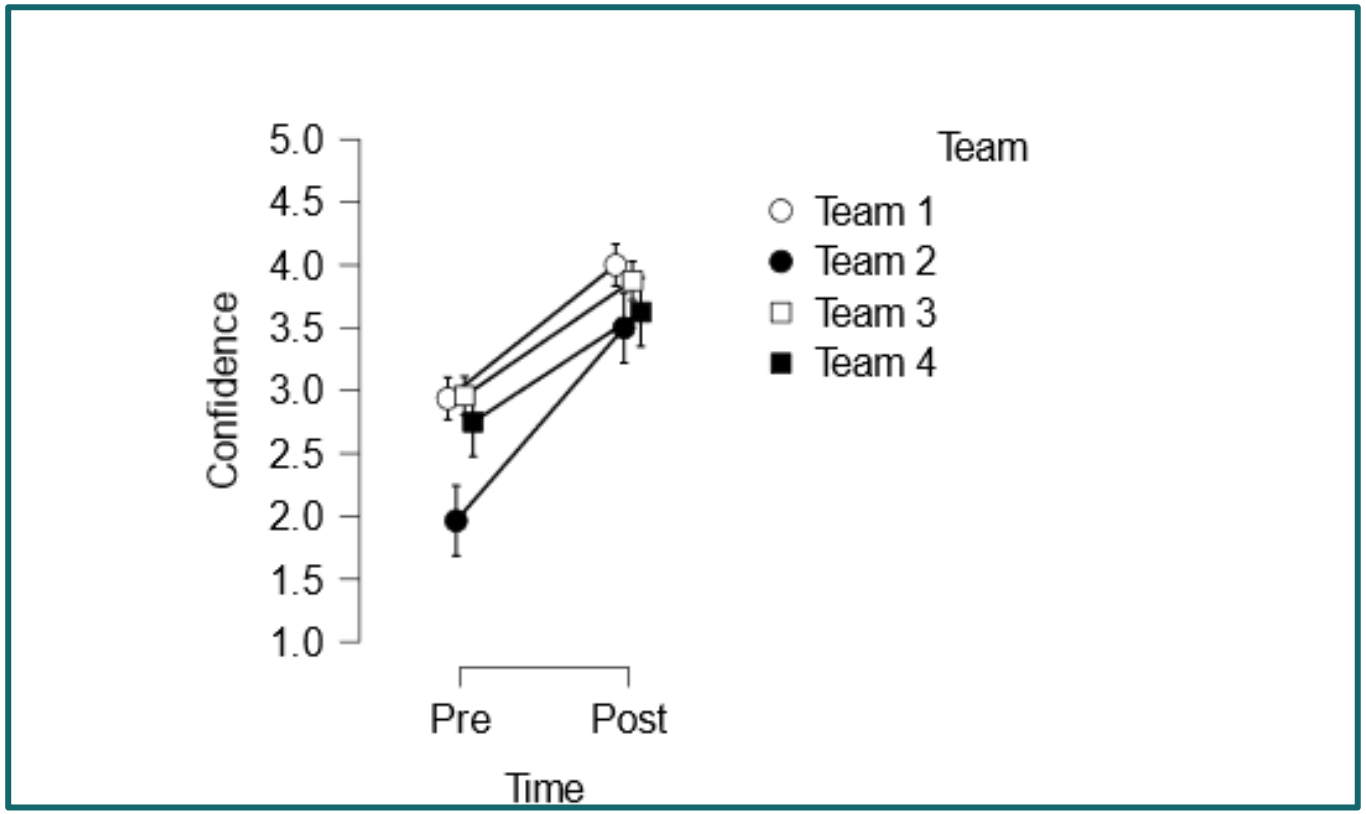
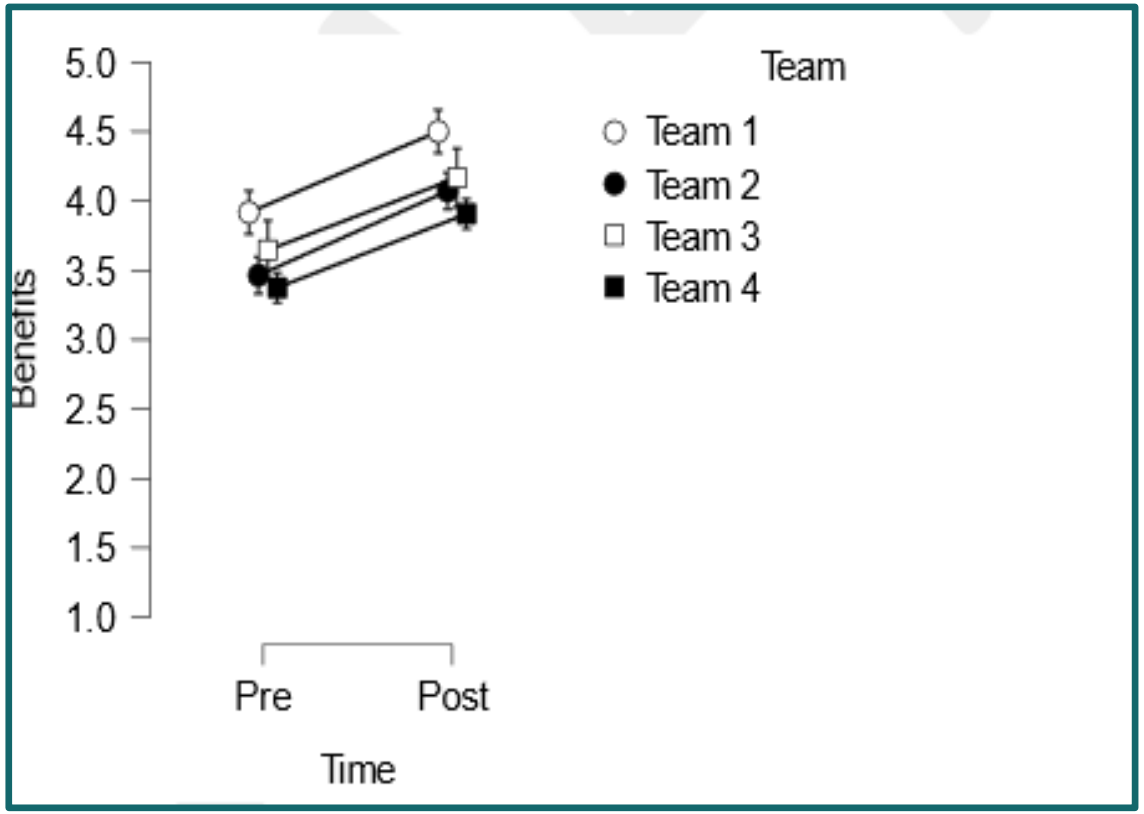
Confidence and Benefits – The Restorative Implementation Scale





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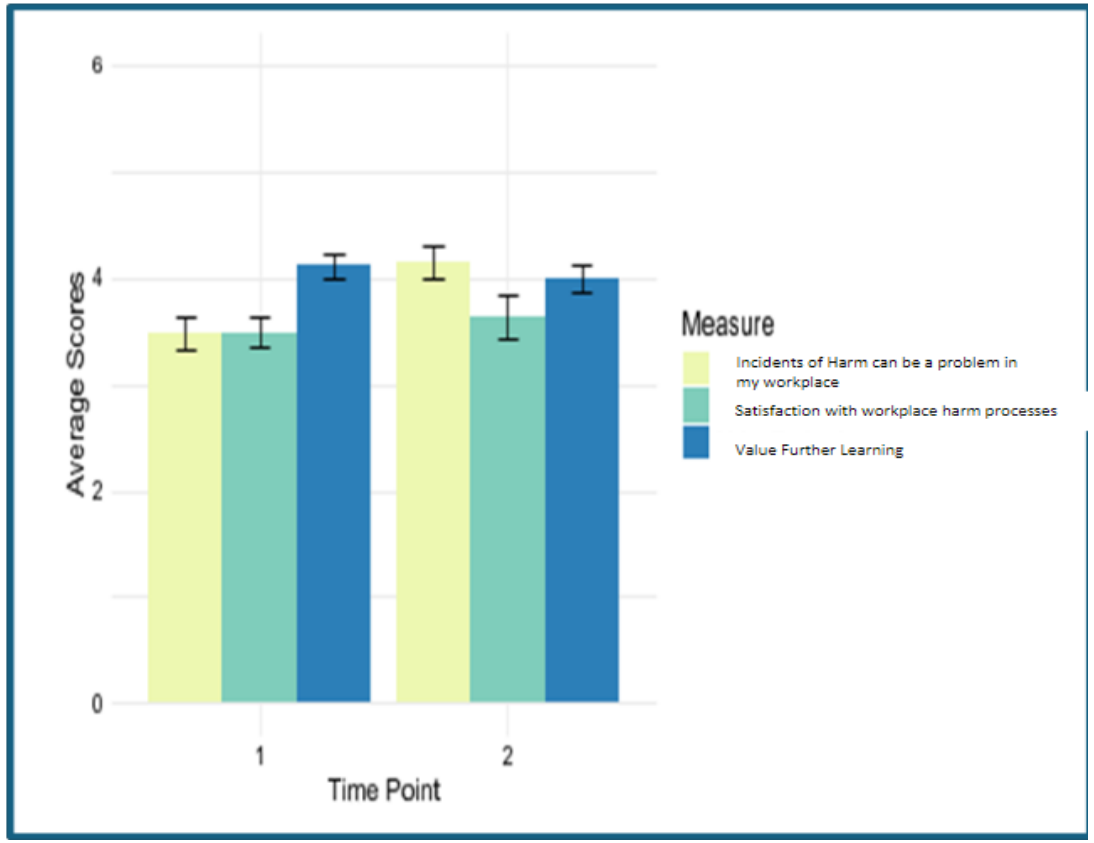
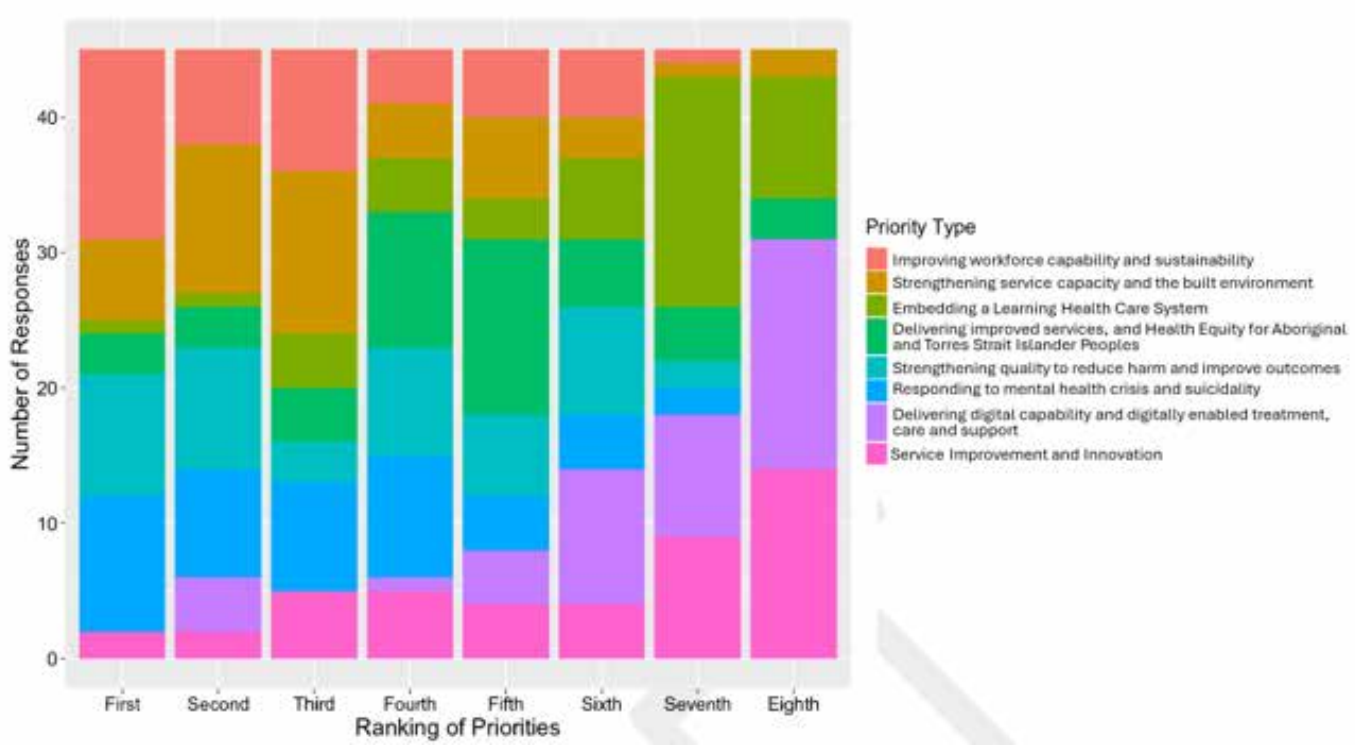
Results across timepoints

Pre and Post comparison for three outcomes pertaining to violence and workplace



Priorities in alignment with BCT



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- All teams were able to identify most significant (positive) changes because of implementing Restorative Practice.
- All teams showed significant increase consistently over time in confidence in using Restorative Practice, and of the perceived benefits of Restorative Practice
- The responses suggested full team presence in workshops, adequate support and resourcing, including positions in relation both to leadership support and restorative engagement were needed to implement change, which was consistent with the external evaluation of Stage One.
- Further work would benefit from increased sample size, and mearsurment assessment of RP use within teams.
- The valuable outcome of this work has been that staff had an increase in confidence in using restorative approaches and could see the potential benefits of a restorative approach in their setting.

"*Building relationships with consumers, improving perception and function of the service less as a punitive method of control and more supportive and effective in the role of the lives of clients*" (Most Significant change, Team 4, p3).

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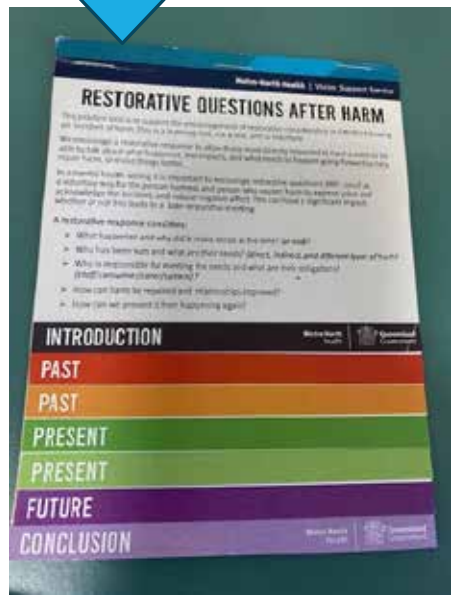
Overall Learnings from our approach

Strengths	Limitations
Shared restorative language (including social discipline window, and circles with consumers)	Small sample size
Use of implementation science approach	Limited Leadership participation (including consultants)
Consumer/staff Collaborative Visual resources	Workforce and workload pressure
Overwhelmingly Positive meaningful workshops	Stronger interest in preventative rather than formal interventions (resources)
RP Lead/support on site to mentor	Measurement of restorative confidence (not RP use or skill)
Multiple benefits to participants using RP (No downside to use RP)	Scope creep
Validation of RP Implementation tool in stage 2	Role clarity (victim support staff)
Participation is opt-in (++)	Cultivating and securing champions
In-reach staff team involvement	
Readiness and enthusiasm	

"We get complacent about harm in general. The expectations are you go to work to cop abuse. There are reports galore – do we do all the reporting? Maybe not all the time" (2, focus group)



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SOCIAL DISCIPLINE WINDOW ACTIVITY

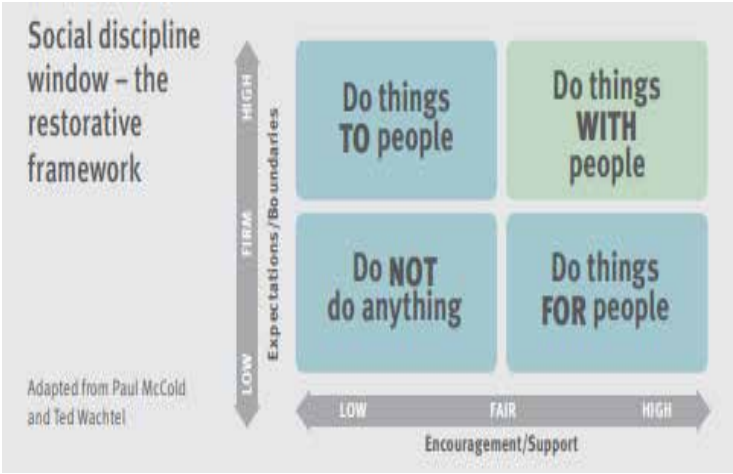
Billie is a consumer in an inpatient mental health setting. They have been increasingly unwell. They have made repeated requests to phone their mother. Billie has frequently asked for a nurse to assist, however they felt not listened to. Billie became increasingly agitated at the nurse, was feeling 'walled', and an inconvenience to what the nurses were doing, having been responded to with "*go back to your room*". Billie initially expresses frustration and swears, before going back to their room, and then attempts to make a complaint to the Team Leader / Lead Clinician about the nurse whom they felt ignored their needs and duty of care. In your groups, consider how this scenario might play out if you were the Team Leader / Lead Clinician responding to the situation in the box allocated you.

In your groups discuss:

- What sort of language, behaviour or responses might you see in your box?
- How might Billie (or others) react to this?
- Decide in your groups who might want to act out a short interaction skit of the Team Leader responding to Billie about the complaint in your allocated box to the rest of the group

  Do not share with other groups what box you are, you will guess this after everyone has played out their skit

  Extra points if you slip a song lyric or title into your responses, but there are no oscars provided for Over the Top acting



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1. I came with…
2. I’m leaving with…

Resources

Further external links:

- The NED Foundation Supports Restorative Practice | NED Foundation
- Restorative Practice | The Prince Charles Hospital (health.qld.gov.au)
- The Mint House (minthouseoxford.co.uk)
- Restorative Practices International www.restorativepracticesinternational.com
- Health | Te Ngāpara Centre for Restorative Practice | Victoria University of Wellington (wgtn.ac.nz)
- https://www.merseycare.nhs.uk/about-us/restorative-just-and-learning-culture
- Building Understanding | Restorative Teaching Tools

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Thankyou J To all those involved in implementation of Restorative Practice in mental health services at The Prince Charles Hospital, including staff, consumers, carers, peer workforce, external stakeholder agencies including Adult Restorative Justice Conferencing, Department of Justice, members of: Steering Committee; Working Groups; Evaluation Group; and Queensland Health Victim Support Service team

Funding and support from:

- Churchill Fellowship Trust to investigate the use of Restorative Justice in mental health services
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- Mental Health Alcohol and Other Drugs Branch for two grants (Queensland Health)
- Queensland Mental Health Commission for funding the external evaluation by Dr Diana Beere

Additional thanks to:

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- Kerrie Sellen of Restorative Journeys
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- Graduate Certificate in Healthcare Innovation project collaborative, Queensland Health and Queensland University of Technology

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- Restorative continuum – adapted from McCold & Wachtel, (2001); 4.3. Restorative Practices Continuum | Defining Restorative | Restorative Practices (iirp.edu)
- Social Discipline window – adapted from Paul McCold and Ted Watchel (2000); 4.1. Social Discipline Window | Defining Restorative | Restorative Practices (iirp.edu)
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