Restorative Conferences within a mental healthcare context: Learnings from a collaborative approach

Queensland Health Victim Support Service Restorative Practice Project in collaboration with Adult Restorative Justice Team

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agenda

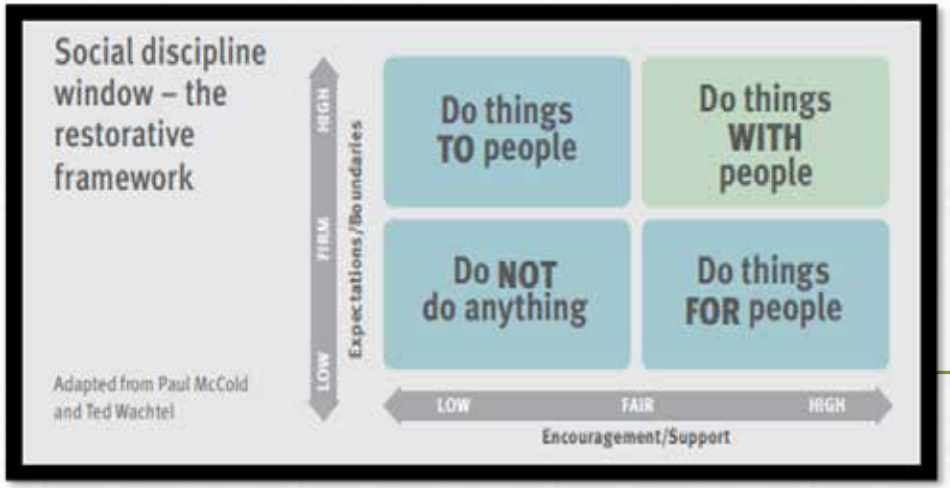
1. Context of RP MH project
2. Case scenario
3. Preparation and Challenges
4. Process
5. Outcomes
6. Reflections
7. Q&A

1. Context of RP MH project

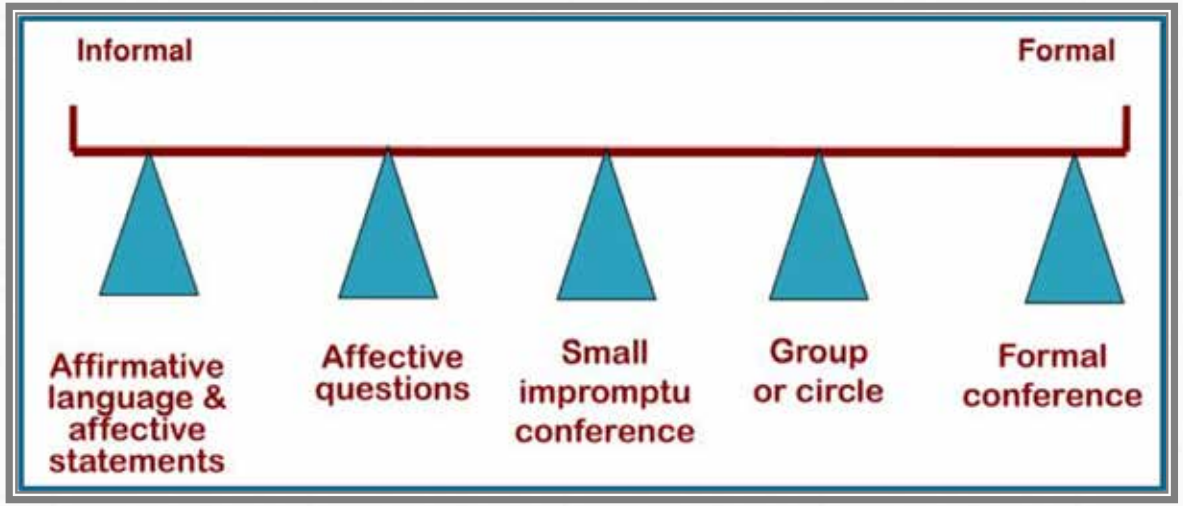
- Incidents of harm in healthcare are a concern for healthcare staff, consumers, carers, leaders
  - Current systemic responses to harm can harm further
  - Opportunities to use restorative approaches demonstrated from RPMH1 (2022)
  - Potential benefits to those involved in restorative interventions in mental ehalth setting (Roswell et al; 2023)

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".

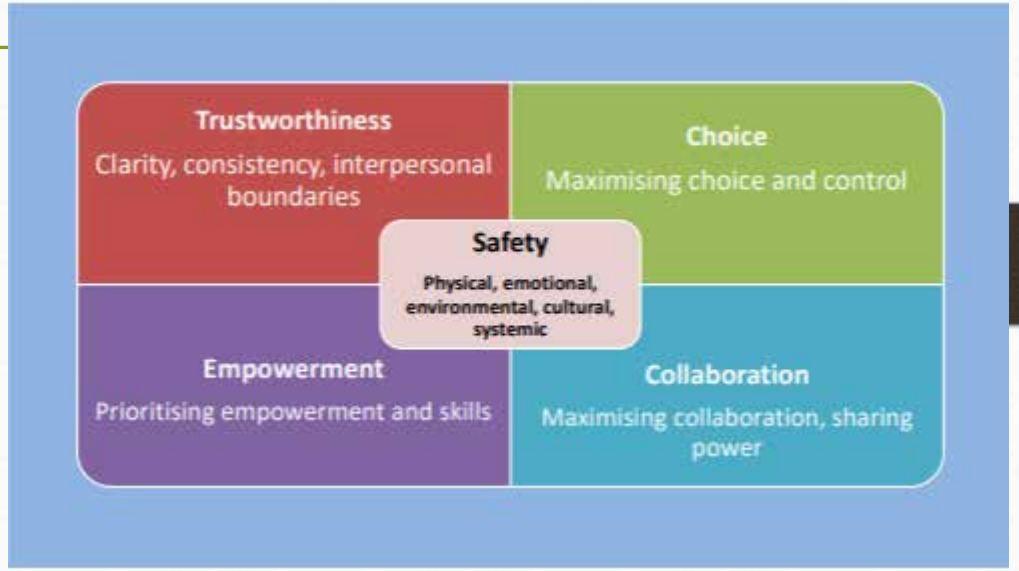
Dr Gerard Drennan, Head of Psychology and Psychotherapy, Lead Psychologist, Forensic and Offender Health Pathway, South London and Maudsley NHS Foundation Trust



Social Discipline Window and Restorative Continuum adapted from IIRP, Wachtel and McCold (2001)



Trauma Informed Framework (MNMH)



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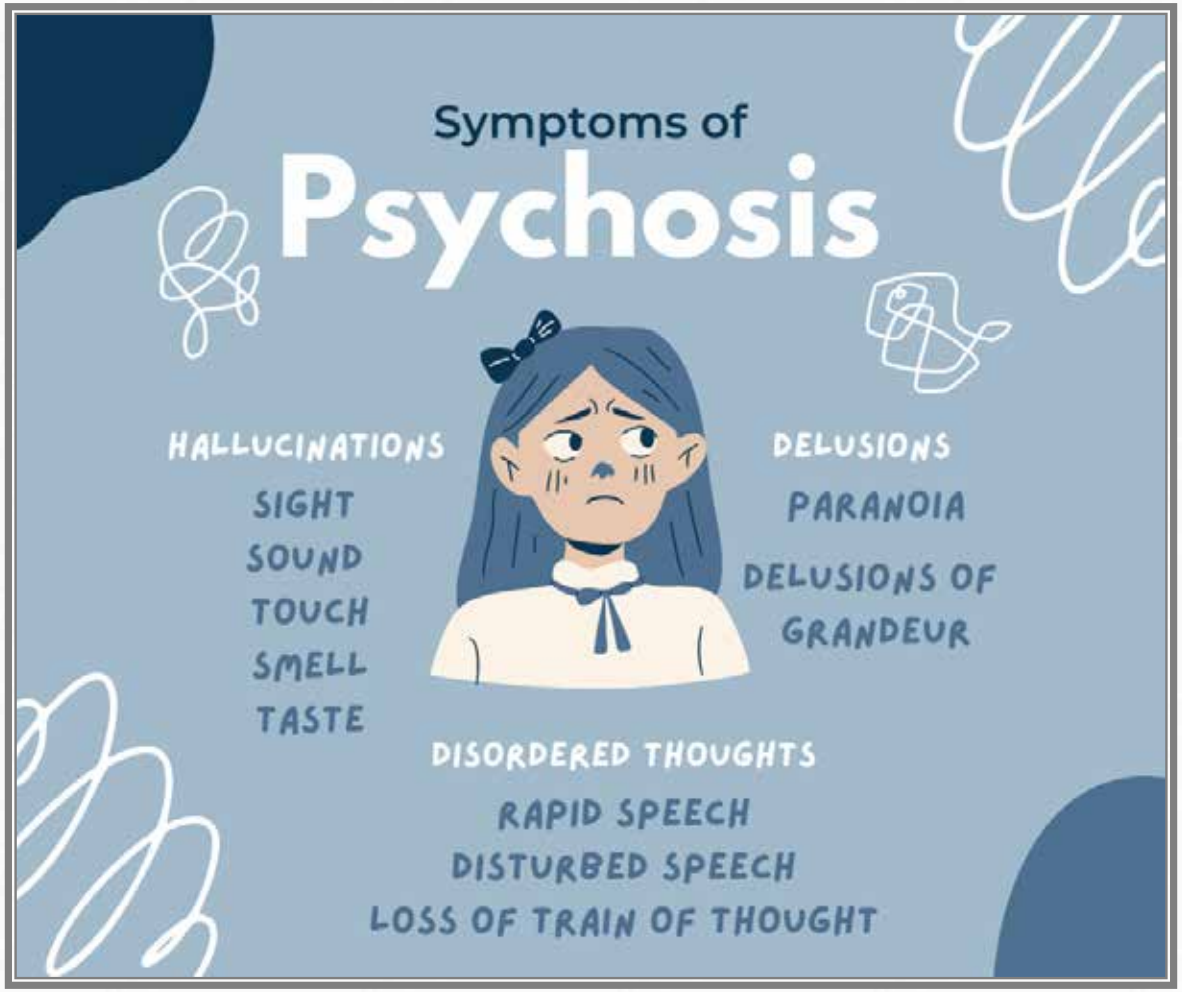
Case Scenario

- Familial harm
- Psychotic episodes
- Relationship with Mental Health Services
- Police / Legal involvement and incarceration
- Fracture of relationship identified for support



Preparation and Challenges

Facilitator supports (collaboratively) assessing:

- Capacity
- Consent/Rights
- Voluntarism
- Suitability (of all)
- Communication needs
- Supports (informal, formal, therapeutic)
- Clear expectations

Additional complexities:

- Pandemic
- Professional Gatekeeping
- Changing MH teams (consent challenges with PH supports)
- Fluctuating readiness

Process

- Communication over phone, video, face to face
- Legal permissions
- Support people readiness(both PH and PCH)
- Pre briefing/meeting plan
- Dual facilitation model

Outcomes

- Relationship repair
- Facilitation and preparedness
- Agreement
- Improved relations with mental health teams
- Responsibility
- Understanding of impacts
- Supports for participants (PH, even though didn't access was good to know there)
- Both PCH and OPH would recommend meeting to others

*(the meeting) help my future relationship with ***. I am so appreciative, thankful and grateful for this opportunity (Person harmed)*

it *was good to see the process allow person harmed / person* [who] *caused harm to share their views and opinions. It was a space that was safe that created openness and honesty (Support Person)*

Reflections

- Collaborative effort with ARJC
- Adaptability and flexibility of timing, communication, and supports
- Collaboration with Mental Health supports regarding preparation
- Importance of choice for person harmed
- Continuity of restorative approach across sector

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Conclusion

- Adapted restorative conferencing processes, together with capacity building for mental health teams, can support the repair of damaged relationships between mental health consumers and those they have harmed, while also enhancing mental health care.

Any Questions?

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