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

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- Nundah Community Mental Health team
- Chermside Community Mental Health team
- Caboolture Hospital Secure Mental Health Rehabilitation Unit
- Queensland Health Victim Support Service.

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# Executive summary

## 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.

# Introduction and 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'[1] and involves more formal processes — restorative interventions — that can be used to respond to incidents of harm (Wachtel 2016). 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 (Cook, Drennan & Callanan 2015).

As restorative justice, RP has been used in the youth justice system in Australia for nearly thirty years (Bazemore, O'Brien & Carey 2005; Braithwaite 1999; Restorative Justice Evaluation Team 2018; Wagland, Blanch & Moore 2013); internationally, the use of restorative justice is also well established in the adult criminal justice system, schools and other educational facilities, and as an option for responding to workplace conflict (Bazemore et al 2005; Cook et al 2015; Drennan 2021; Karp & Conrad 2005; Karp & Schachter 2018; Morrison, Blood & Thorsborne 2005). An extensive body of research on the use of restorative justice in such settings has demonstrated benefits for not only the person/s harmed, which may include community members who are indirectly harmed, but also the person who caused the harm; however, evidence about the effectiveness of restorative interventions in reducing offending is mixed (Drennan 2021; Larsen 2014; Latimer, Dowden & Muise 2005; O'Connell 2018; Piggott & Wood 2018; van Denderen et al 2020).

Perceptions that forensic mental health consumers would not have the necessary capacity for empathy, accountability or moral responsibility to participate in restorative interventions — and furthermore would be too unwell to do so — may have held back the development of RP in forensic mental health settings (Drennan & Swanepoel 2021, Hew 2020). Conceptually and theoretically, however, there appear to be no barriers to using RP with people who have a mental illness, given appropriate assessment and planning (Drennan & Swanepoel 2021, Garner & Hafemeister and Hafemeister et al, both cited in Cook et al 2015, van Denderen et al 2020). Moreover, refusal of the opportunity to participate in a restorative intervention on the basis of a person's presumed lack of capacity may amount to a denial of human rights and access to justice (Condell, cited in Hew 2020). Assessment of a mental health consumer's capacity to consent and engage in a restorative intervention is best undertaken by their multidisciplinary treating team and needs to consider the fluctuating nature of mental illness and the variability of capacity (Cook 2019, Cook et al 2015, Power 2017), in addition to risk management and security issues. Thus Hew (2020) suggested that the question for the treating team is not whether the consumer has the capacity to participate, but rather, how they can best be supported to optimise their capacity to participate and to benefit from the process (see also Tapp et al 2020, van Denderen et al 2020).

[1] According to the International Institute for Restorative Practices, 'restorative justice' is a subset of practices on the RP continuum that respond, after the event, to individual incidents of wrongdoing (Wachtel 2016).

That said, a fundamental principle of RP is that no further harm should be done (Braithwaite 1999, Drennan & Swanepoel 2021). For this reason, some people will not be considered suitable participants in restorative interventions. This includes people who deny or minimise the incident where harm was caused, or who are motivated by a desire to humiliate, threaten, harm or undermine the other person/s involved, or to gain some kind of tangible benefit (e.g., to avoid punishment or accrue privileges). It seems unlikely that mental health consumers who have been diagnosed as psychopathic, have a severe anti-social personality disorder or are at risk of self-harm will be considered suitable participants in facilitated restorative interventions (Dhami, Mantle & Fox 2009). However, a study by van Denderen et al (2020) suggests that, in terms of either psychopathology or type of offence, there are no clear criteria for excluding offenders with a mental illness from opportunities to participate in restorative interventions. Rather, the 35 social workers interviewed for that study identified offenders' problem awareness, the stability of their psychiatric condition and their ability to keep to an agreement as important factors for consideration.

The implementation in mental health services of the broader continuum of both proactive and reactive practices encompassed within RP may have a range of benefits for staff, consumers and the services themselves. Mental health professionals, particularly nursing staff, are vulnerable to aggression and violence from consumers, which can negatively affect their sense of safety, job satisfaction and productivity (Fröhlich et al 2018) as well as having significant physical and mental health impacts for individual staff members. Carroll and Reisel (2018) noted that effective healthcare is dependent on relationships of trust both within teams and between staff and patients, and that within a restorative culture, issues of tension can be addressed as they arise. Furthermore, in emphasising the importance of repairing and building relationships, RP can help to build social capital (Morrison et al 2005), which de Jong and Schout (2011) noted is often lacking among public mental health consumers, to the detriment of their recovery. In addition, Drennan (2021) has argued that restorative interventions can complement psychotherapeutic work among both forensic patients and those they have harmed. The former may struggle to come to terms with having harmed someone else and find themselves unable to move on, while the latter may be similarly paralysed by unresolved anger, fear or other emotions.

Cultural issues may present some challenges for the implementation of RP in mental health services, particularly forensic and other secure facilities. For example, mental health staff who have been harmed by consumers may be reluctant to engage in restorative interventions that potentially require them to step out of their professional roles, disclose personal information and reveal themselves to be vulnerable. Staff may feel that this will shift the power relationships between themselves and consumers and expose them to the risk of further harm in the future (Cook 2019, Cook et al 2015, Drennan & Swanepoel 2021, Power 2017, Hew 2018).

In addition, while the focus in RP on repair and healing is consistent with the mental health recovery model that is ascendant in mental health services (Cook 2019, Hew 2020) and with an emerging trend towards trauma-informed care (Drennan & Swanepoel 2021), the voluntary nature of RP may be fundamentally at odds with the highly controlled environment of secure mental health facilities, where treatment is underpinned by involuntarism and coercion (Drennan & Swanepoel 2021, Hew 2020). Secure mental health facilities have a dual focus on managing risk and providing therapeutic interventions that promote consumers' rehabilitation and recovery (Cook 2019) and finding an appropriate balance between the two can be challenging (Hew 2020). An over-emphasis on

managing risk can mean that secure mental health facilities struggle to fully embrace the mental health recovery model, to the detriment of consumers' long-term recovery (Barker, cited in Hew 2020). On the other hand, an over-emphasis on consumers' recovery may lead to unsafe outcomes. While acknowledging the latter point, Hew (2020) has suggested that an increased focus by secure mental health services on fostering recovery may help them to overcome the challenges of implementing RP.

At the same time, it is important for services that are focused on providing therapeutic opportunities for consumers who have caused harm to bear in mind the need to keep the person harmed at the centre of any restorative intervention (Cook 2019). The potential therapeutic benefits of a restorative intervention for a consumer who has caused harm must never be prioritised over the needs of the person harmed (Cook 2019; Drennan, Cook & Kiernan, cited in Hew 2020; Drennan & Swanepoel 2021).

Since 2012, RP has been implemented in mental health and forensic mental health services in England, The Netherlands and Canada (Power 2017, van Denderen et al 2020). Yet there is little published research evidence so far to indicate the effectiveness of RP in either preventing or responding to conflict in mental health settings (Drennan & Swanepoel 2021, Hew 2020, van Denderen et al 2020). A literature search identified only a small qualitative exploratory study undertaken within a secure forensic mental health service in England (Cook et al 2015), a discussion of three case studies of restorative interventions within the same service (Cook 2019) and a single case study of a facilitated restorative meeting in another English forensic mental health setting (Tapp et al 2020). Another study conducted in The Netherlands by van Denderen et al (2020) explored social workers' experiences with contact between forensic psychiatric patients and the people they had harmed, although, as the reasons for initiating contact were not necessarily to repair harm, these cases were not strictly examples of RP.

Cook et al (2015) found benefits for all stakeholders from the use of RP, including, for persons harmed, a sense that they had been listened to, a loss of fear of being assaulted again, and feeling less like a victim. For persons who caused harm, benefits included improved relationships and a greater understanding of the nature and extent of the harm caused, leading to changes in feelings, thinking and behaviour. In addition, service staff saw RP as consistent with and supportive of their work towards therapeutic goals and most study participants supported its continued use within the service.

In the study by van Denderen et al (2020), 35 social workers from four forensic psychiatric hospitals discussed a total of 57 cases where contact between patients and the people they had harmed had been initiated by either the patient, a person harmed by them or the patient's social worker. Not all cases resulted in contact; in about one-third, the preparation process commenced, but was discontinued when one or both of the parties declined to proceed further. Nevertheless, the social workers described some cases among this latter group where — as Cook et al (2015) also found — participation in the preparation process had itself been beneficial for the people involved.

In the 29 cases where contact had occurred — either face-to-face or by other means — the social workers described a range of positive effects for both parties. The benefits they described for the patients who had caused harm were similar to those described by Cook et al (2015); they included restoration of family relationships, opportunities to express regret, opportunities to receive answers

to questions they had for the people they had harmed, reduced anxiety about the possibility of retaliation, increased insight into the circumstances that led them to cause harm, and increased ability to cope with the consequences of their actions. The social workers also identified a range of benefits for the people who had been harmed, and again they were consistent with those described by Cook et al (2015). They included having questions they had for the offenders answered, being able to talk to the offenders about the ways in which the incident had affected them, and increased insight into the offenders' mental illness (van Denderen et al 2020). However, one of several limitations of this study, acknowledged by the authors, was that its insights into the benefits of contact between forensic mental health patients and the people they have harmed were gained through interviews with the patients' social workers, rather than the accounts of the parties involved.

The single case study by Tapp et al (2020) provided some further evidence that restorative interventions can be used safely within a secure forensic mental health setting and that a person with difficulties in social and emotional processing may be capable of participating in such an intervention. Participants in the intervention described in this case study, including facilitators and support persons as well as the person harmed and the person who caused harm, all observed or self-reported restorative outcomes.

In discussing three case studies, Cook (2019) noted that while one of the restorative interventions clearly had a successful outcome, the other two were not so easily identifiable as success stories and raised questions about how best to evaluate the effectiveness of such interventions. She concluded, however, that restorative interventions can help maintain the therapeutic climate of a secure ward and, as argued by Drennan (2021), can also complement — but not replace — both consumers' clinical treatment and the support options available to mental health staff who have been harmed by consumers.

The studies discussed above all focused on the reactive use of RP in the form of facilitated restorative interventions; no studies appear to have yet explored the benefits of using RP proactively in mental health settings to prevent or reduce conflict and improve relationships. Nor did the literature search identify any research evidence on what might constitute good practice in implementing RP in mental health services. However, the paucity of the evidence base for RP in mental health settings is not surprising, given that — according to Drennan and Swanepoel (2021) — establishing RP in secure mental health facilities is a long-term project. They also argued that its use in mental health settings generally has so far been *too piecemeal and fragmentary to support a quantitative outcome study* (p.18). In this context, the project to implement RP in both community-based and secure mental health services at The Prince Charles Hospital (TPCH) — the first of its kind in Australia — offered a unique opportunity to help strengthen the evidence base for RP in mental health settings by conducting a two-year mixed methods evaluation.

# Methods

## Evaluation context

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 period of research; internal, cross-agency and international consultation; model development and planning; and other preparatory work. Both the preparatory work and the implementation of RP were led and managed by Queensland Health Victim Support Services (QHVSS, a unit within Metro North Mental Health), which employed a dedicated 0.7 FTE RP project coordinator (known as the RP Lead) for this purpose.

**Preparatory work**

The extensive preparatory work included the establishment in mid-2018 of a cross-agency stakeholder group, whose purpose was to collaborate in the development of a draft model of RP that could be implemented in public mental health services in the Queensland context. It was to be based on learnings from international research and experience in implementing RP in forensic and other mental health services in Canada, England and the Netherlands, as well as from experience of providing restorative justice services within the Queensland justice system.

Endorsed by the Metro North Mental Health Executive, the stakeholder group included:

- Director, QHVSS
- Manager, Adult Restorative Justice Conferencing Unit, Department of Justice and Attorney-General
- restorative justice trainers from Youth Justice
- Restorative Justice Manager and practitioner from a specialist service — the Mater Family and Youth Counselling Service — that provides restorative justice services to young people involved in sexual offending and their victims
- Advanced Social Worker from TPCH Secure Mental Health Rehabilitation Unit (SMHRU), Metro North Mental Health
- Chief Executive Officer, Queensland Homicide Victim Support Group
- representatives from the Office of the Chief Psychiatrist, Queensland Health
- representatives from Queensland Forensic Mental Health services.

In addition, a focus group of mental health consumers provided input into the development of the model, and targeted consultation occurred with academics and local practitioners with expertise in restorative justice and RP.

The RP model proposed by the stakeholder group was endorsed by the Metro North Mental Health Executive in early 2019. Based on a range of factors, including a history of assaults of SMHRU staff and the fact that a SMHRU staff member had input into the development of the model, the Metro North Mental Health Executive determined that implementation of RP in TPCH mental health services would commence in the SMHRU and later extend to community mental health (CMH) services.

QHVSS convened initial meetings with the SMHRU leadership group in the second quarter of 2019, to share details about the proposed model and discuss opportunities to commence introducing it to SMHRU staff. Efforts to engage staff interest in restorative justice and how it potentially could be used in a secure mental health service included two half-day information sessions, which were delivered in June 2019 by an external restorative justice conferencing trainer and practitioner. Feedback collected by QHVSS after these sessions indicated that SMHRU staff found them interesting; however, some felt that the concept and processes were not suitable for SMHRU consumers.

Follow-up discussions between QHVSS staff and the SMHRU leadership group led to revised strategies being developed to support the implementation of RP in the SMHRU. These included:

- RP training for the leadership group, prior to the staff being trained
- development of visual resources
- changing to a different external restorative justice trainer
- expanding the RP model further, to highlight the application of RP interventions on a continuum, to both prevent violence and respond after violent incidents
- a three-day training package for staff, developed and delivered by the external trainer in collaboration with QHVSS staff
- the inclusion of the SMHRU's Advanced Social Worker and Nurse Unit Manager (NUM) as members of the Steering Committee established to oversee the implementation of RP in TPCH mental health services.

**Implementation**

Focusing initially on the SMHRU, and then — from mid-2020 — extending to the Nundah and Chermside CMH teams, the implementation 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 had 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.

TPCH SMHRU is a 24-hour, 7-day medium-secure extended treatment facility that provides multidisciplinary clinical care and support for up to 20 males over the age of 18 years who have persistent and disabling symptoms of mental illness and cannot be adequately supported in other inpatient settings. While the SMHRU is not a forensic mental health facility, at any given time several of its residents may be under forensic mental health orders as a result of alleged serious offences. The SMHRU may provide short-term inpatient treatment and stabilisation for consumers who have proven difficult to treat in less restrictive settings. However, the length of stay is generally around two to five years and when the RP project began, some SMHRU residents had been there for more than ten years.

The Nundah and Chermside CMH teams provide a range of community-based mental health interventions to adults (over the age of 18 years) living in their catchment areas who have complex mental health disorders, experience moderate to severe impairment in functioning due to their mental illness, and for whom psychosocial support is inappropriate or insufficient on its own.

Consumers supported by these CMH teams may be under forensic mental health orders. Services provided by the multidisciplinary Nundah and Chermside CMH teams include information, assessment, case management, treatment, support, consultations and referral.

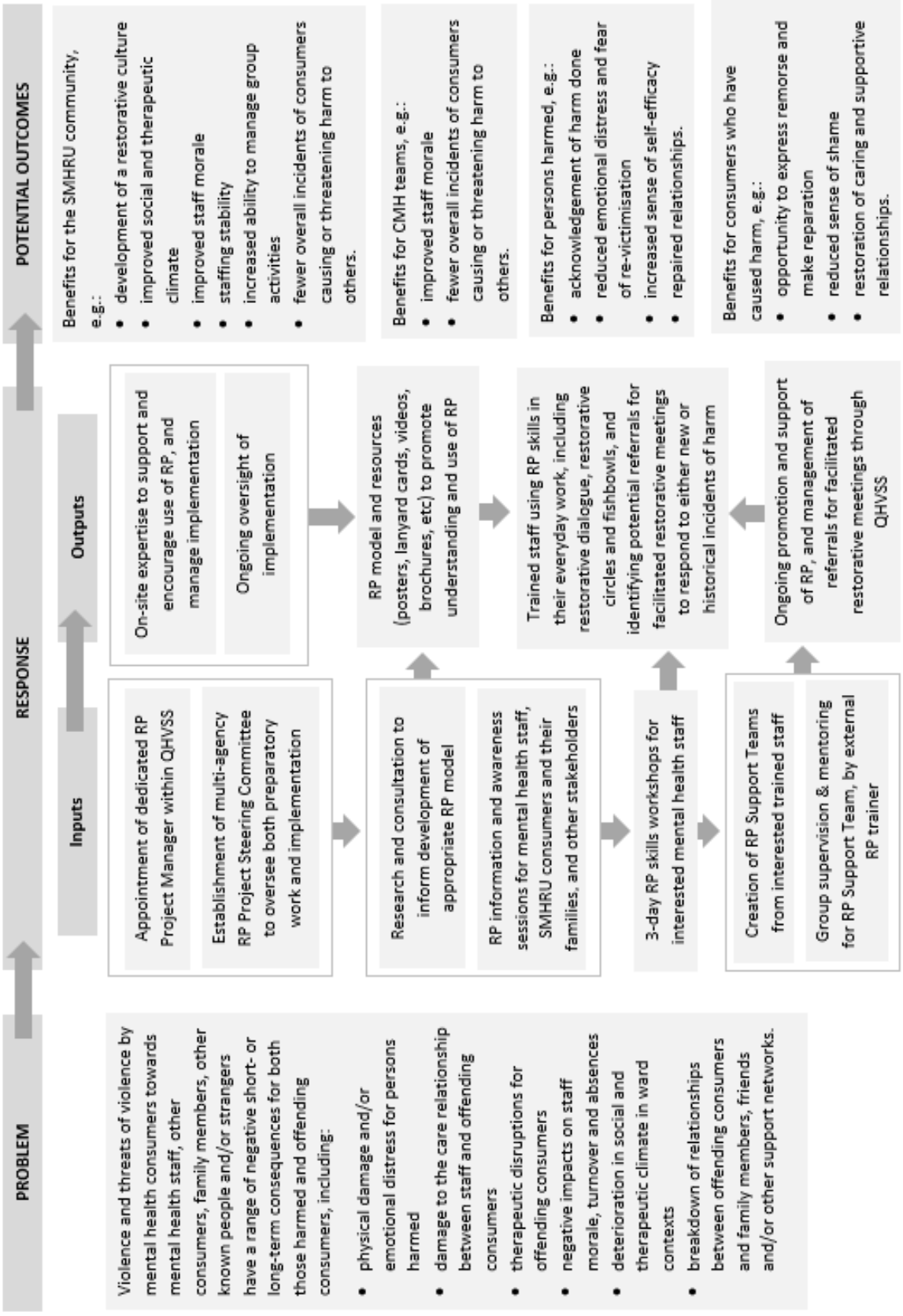
Figure 1 illustrates the program logic (theory of change) that underpinned the project to implement RP in these three service areas within TPCH Mental Health.

Key elements of the RP implementation project included:

- The three-day RP skills workshops. These were held in early December 2019, leading to the introduction of RP into the SMHRU, and in mid-July 2020, to begin introducing RP into the Nundah and Chermside CMH teams. Two further workshops were held in October 2020 and May/June 2021 for other interested staff across the three teams. Participants all received a training booklet that detailed the key elements of the RP model to be implemented as well as the principles and different practices of RP.
- RP information and awareness sessions for SMHRU consumers and their families.
- The distribution of resources such as posters, prompt cards for staff lanyards, and videos to encourage the use of RP by staff and also, in the SMHRU, by consumers.
- The principle that engagement in RP should always be a voluntary. For this reason, the three-day RP skills workshops were not mandatory for staff in the three participating teams, and even those who completed the training were not obliged to use RP. Indeed, in June 2021, the Chermside CMH team opted out of the RP project.
- On-site support from the RP Lead, who spent at least one day per week at each implementation site.
- A multi-agency Steering Committee, chaired by the Operations Director, TPCH Mental Health, to provide project oversight, together with a multi-agency committee to monitor and provide advice on the project's evaluation.
- The establishment of RP Support Teams (RPSTs) within the SMHRU and the Nundah CMH team, to provide ongoing support for the use of RP.[2]
- Group supervision and mentoring for RPST members, provided by the external RP trainer.
- Management of referrals to facilitated restorative meetings by QHVSS.
- Through an agreement with the Department of Justice and Attorney-General, the provision of external RP facilitators from that agency's Adult Restorative Justice Conferencing (ARJC) team, to prepare potential participants in formal restorative meetings and to facilitate those meetings (or alternative restorative interventions, as appropriate).
- Support from RPST members and/or QHVSS, as appropriate, to participants in facilitated restorative meetings.

[2] An RPST was originally planned for the Chermside CMH team as well but was never established.

**Figure 1: RP project logic model**



A range of practices on the RP continuum were introduced to the SMHRU and the Nundah and Chermside CMH teams through the three-day skills workshops and the various resources developed for the project (see Appendices 1-4 for examples). These practices included the following[3]:

- Restorative language, which includes affective statements that communicate the speaker's feelings in a respectful way, together with affective questions, which invite the person to whom they are directed to reflect on the way their behaviour has impacted on others. Restorative language may be used either proactively, to develop and strengthen relationships, or reactively, following incidents of conflict or harm, to have respectful conversations about what happened, who was affected and how, who can take responsibility for what aspects of the incident, and how best to use the strengths of those involved and/or affected to repair the harm, including harm to relationships.

- Impromptu restorative meetings, which are less formal and structured than facilitated restorative meetings (see below) and can be used to respond more immediately to relatively minor incidents of conflict through the use of affective questions with the parties involved.

- Non-hierarchical 'restorative circles', in which participants typically pass a small object — a 'talking piece' — from one to another to help ensure that each person has an opportunity to speak and be heard without interruption, in a safe and respectful atmosphere. Circles may be used either proactively, to develop relationships and build community, or reactively, as a group response to wrongdoing and conflict.

- Solution-focused 'fishbowls', which are tightly-structured variations on restorative circles that may be used to collaboratively solve identified problems.

- Facilitated restorative meetings — whereby a trained, non-judgemental facilitator meets separately with a person who has caused harm and those who have experienced harm, to assess and prepare them for a face-to-face meeting or alternative communication (e.g., shuttle communication or communication by letter or other means) — following incidents of harm or threatened harm. Facilitated restorative meetings may respond to recent incidents of harm or to historical incidents, which may include the incident that led to the person responsible becoming a patient in the SMHRU and/or being placed under a forensic mental health order.

The RP continuum thus ranges from high-volume, low-intensity practices (e.g., restorative language) to low-volume, high-intensity interventions in the form of facilitated restorative meetings (Drennan & Swanepoel 2021), as shown in the diagram at Appendix 1.

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. Thus the evaluation began during the early stages of what became a worldwide COVID-19 pandemic. The pandemic continued to impact on everyday life in a range of ways throughout the study period, but impacted public health and mental health services particularly severely.

[3] Descriptions of these practices have been drawn from multiple sources, primarily Hew (2020), QHVSS, and Wachtel (2016).

## Design

Informed by the program logic depicted in Figure 1, the evaluation used a mixed methods approach 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 an 18-month process study. This was conducted concurrently with a two-year outcomes study that addressed the three parts of KEQ 6, focusing primarily on outcomes in TPCH SMHRU.

Data collection for both components of the evaluation commenced in early June 2020, following ethical clearance from TPCH Human Research Ethics Committee. However, the process study also drew on data collected by QHVSS from early December 2019, when the first three-day RP skills workshop was held.

## Data sources for the process study

To help answer each of the five KEQs that guided the process study, a variety of data were collected from several sources, as shown in Table 1.

**Workshop feedback**

Over a period of 18 months, the project team organised four three-day workshops with an external RP trainer to enable interested staff from the SMHRU and the two CMH teams to learn a range of RP skills and gain a better understanding of the RP project. The first workshop was held in early December 2019, with subsequent workshops held in July 2020, October 2020 and May-June 2021. At the end of each workshop, participants were encouraged by the RP Lead to complete a two- page feedback form, preferably before leaving. The feedback form comprised a series of short statements, with which respondents were asked to indicate their level of agreement, as well as several open-ended questions (see Appendix 5). Most workshop participants returned their completed feedback forms before leaving the workshop, but a small number emailed theirs to the RP Lead in the following days. The RP Lead then emailed scanned copies of all the completed feedback forms to the researcher for data entry and analysis.

**Table 1: Process study methods**

| KEY PROCESS EVALUATION QUESTIONS | PARTICIPANTS | DATA COLLECTION METHODS | ANALYSIS |
|---|---|---|---|
| **1. How well were TPCH mental health services prepared for the implementation of RP?** | • Participants in four 3-day RP skills workshops<br>• SMHRU, Nundah CMH and Chermside CMH staff<br>• Key informants from Metro North Mental Health | • Post-workshop feedback sheets, comprising both structured and open-ended questions<br>• 3 structured online surveys with 'additional comments' option<br>• Semi-structured one-to-one interviews | Descriptive statistics; thematic analysis<br>Thematic analysis |
| **2. What problems were encountered during the implementation of RP in TPCH mental health services and how were they overcome?** | • Key informants from Metro North Mental Health | • Semi-structured one-to-one interviews<br>• RP Steering Committee and RP Support Team meeting minutes | Thematic analysis<br>Content analysis |
| **3. What aspects of the model or its implementation worked well?** | • Participants in four 3-day RP skills workshops<br>• SMHRU, Nundah CMH and Chermside CMH staff<br>• Key informants from Metro North Mental Health | • Post-workshop feedback sheets, comprising both structured and open-ended questions<br>• 3 structured online surveys with 'additional comments' option<br>• Semi-structured one-to-one interviews<br>• RP Steering Committee and RP Support Team meeting minutes | Descriptive statistics; thematic analysis<br>Thematic analysis<br>Content analysis |
| **4. What improvements could be made to achieve better outcomes?** | • Key informants from Metro North Mental Health | • Semi-structured one-to-one interviews | Thematic analysis |
| **5. What is needed to ensure the sustainability of RP in TPCH mental health services?** | • Participants in four 3-day RP skills workshops<br>• Key informants from Metro North Mental Health | • Post-workshop feedback sheets —open-ended question<br>• Semi-structured one-to-one interviews | Thematic analysis |

**Online staff surveys**

Three structured online surveys were conducted at intervals of roughly seven months. The first of these, conducted seven months after the RP project commenced, was targeted to SMHRU staff only, as the project was at that time only just being extended to include the two CMH teams. Survey 2, conducted a little more than six months after the project was rolled out to the two CMH teams, was targeted to staff of all three work areas. Survey 3, conducted approximately seven months later, was targeted only to staff in the SMHRU and Nundah CMH, as Chermside CMH had by that time opted out of the RP project.

The surveys, designed using *Survey Monkey* ('Premier' version), were essentially the same on each occasion, the only difference of note being that in Surveys 2 and 3, one of the items in Survey 1 was split into two items. All three surveys sought information from staff about the adequacy of the RP training they received, their confidence in using RP, and the extent to which they were actually using it. The surveys used skip logic, so the number of items varied — as shown in Table 2 — depending on whether respondents had done any RP training, but all of them included an optional open-ended question at the end.

**Table 2: Online staff surveys summary details**

| | Survey 1 | Survey 2 | Survey 3 |
|---|---|---|---|
| **Target staff** | SMHRU | SMHRU, Nundah CMH, Chermside CMH | SMHRU, Nundah CMH |
| **Dates open (days)** | 19 July to 12 August 2020 (24) | 12 January to 3 February 2021 (23) | 3 to 23 August 2021 (21) |
| **No. of items, including one optional open-ended item** | Up to 13 | Up to 14 | Up to 14 |

For all three surveys, staff were invited to participate by means of an email from their team leader (or the NUM in the case of the SMHRU), which contained a web link to the survey. The surveys were further promoted via follow-up emails, posters in the three work areas, and several in-person reminders/prompts from the RP Lead, members of the RPST, and the team leaders. In the SMHRU, where nursing staff do not have their own computers, active support from the NUM allowed on-duty nursing staff to take time away from the nurses' station to complete the survey at a computer in the SMHRU conference room. For Survey 3, a QR code was created and promoted to staff so that they had the option of completing the survey on their smartphones. Each survey was open for approximately three weeks, as shown above in Table 2.

**One-to-one stakeholder interviews**

Two rounds of semi-structured one-to-one interviews with stakeholders in the RP project were conducted for the process study. Both sets of interviews sought stakeholders' views on the progress of the implementation of RP — including how well they thought they and other stakeholders had been prepared for the introduction of RP, the challenges experienced during implementation, things that had worked well, and how the RP model and/or its implementation might be improved.

The first round of interviews in August 2020 focused only on implementation in the SMHRU, as roll-out of the RP project to the Nundah and Chermside CMH teams had only just commenced. Stakeholders targeted for the first round included the QHVSS project team, members of the RP Project Steering Committee and the SMHRU RPST, other SMHRU staff, and in-reach staff familiar with the project.

The second round of interviews was conducted over the period from late February to early June 2021 — a much longer period than had been originally planned, due to difficulties in recruiting participants. The second round focused on implementation in both the SMHRU and the two CMH teams, and therefore targeted staff in those two teams as well as the same people targeted during the first round. Given the focus on implementation issues, interviews were not sought with consumers during either of the two rounds.

Interview participants were sought by several means, including via emails from the NUM and the two team leaders to all their staff, encouraging them to participate and inviting them to contact the researcher to organise an interview. Posters in the three work areas also advertised the interviews and invited participation. In addition, direct approaches were made by email or in person to stakeholders identified by the RP Lead and/or team leaders as key sources of information; this method was particularly useful for recruiting stakeholders who were not SMHRU or CMH staff. On several occasions, with the permission of team leaders, the researcher spent the day on site and made this known to staff on duty, so that those who were interested in participating in an interview could do so relatively easily if an opportunity arose during their shift. However, COVID-19 lockdown periods, particularly during the second round of interviews, limited the use of this recruitment method. They also impacted on the availability of most stakeholders to participate in interviews, as mental health staff tended to be even busier than usual during lockdown periods.

Stakeholders' informal agreement to participate in an interview was followed up in all cases by the provision, either by email or in person, of copies of both the participant information and consent form (see Appendix 6 for an example from the first round) — which participants were required to sign and return before their interview commenced — and the relevant question guide (Appendices 7 and 8). This was followed by the scheduling of a date and time for the interview (in cases where the interview was not held on the spot).

Interviews were conducted either in person at the participant's workplace or via online meeting software (using *Zoom* or *Microsoft Teams*) and ranged in length from 15 to 50 minutes. All but one of the interviews were digitally recorded and professionally transcribed, the exception being an interview with a participant who did not want to be recorded but was happy for detailed notes to be taken. All interview transcripts were checked against the recordings for accuracy.

**Project documentation**

Documents collected from the project team included minutes of RP Steering Committee and RPST meetings, copies of resources developed to promote awareness of the project and/or the use RP, and copies of miscellaneous feedback from stakeholders who gave permission for it to be used for the evaluation.

## Data sources for the outcomes study

For the outcomes study, which was designed to answer the three parts of KEQ 6, a variety of data were collected from several sources, as shown in Table 3.

**Surveys of social climate**

Two surveys of social climate using the EssenCES (Schalast et al 2008) were conducted approximately 23 months apart in TPCH SMHRU and, for comparison purposes, the Caboolture Hospital SMHRU. The EssenCES was originally developed to measure the social and therapeutic atmosphere of forensic psychiatric wards, a crucial factor in the health and wellbeing of both consumers and staff, and in the effectiveness of therapeutic interventions (Schalast et al 2008). Its psychometric properties have subsequently been validated in a range of secure settings (Day et al 2011, Siess & Schalast 2017, Tonkin 2015). However, there have been insufficient studies to exclude the possibility that it is insensitive to changes within wards over time (Dickens et al 2014). The EssenCES is a single-page paper-based survey comprising 17 items. Each item comprises a short statement to which respondents are asked to indicate the extent of their agreement, using a five-point scale ranging from 'not at all' to 'very much' (see Appendix 9).

The EssenCES measures three dimensions of social climate:

- 'Patients' cohesion and mutual support', which indicates the extent to which characteristics of a therapeutic community exist among consumers
- 'Experienced safety (vs. threat of aggression and violence)', a crucial dimension of a therapeutic and rehabilitative climate in both general and forensic psychiatry
- 'Therapeutic hold', which refers to the quality of relationships between consumers and staff (Schalast et al 2008).

The survey was first administered in TPCH SMHRU during the period 4-15 June 2020 inclusive (12 days) — roughly six months after the start of the RP project — and in the Caboolture Hospital SMHRU during the period 22-29 June 2020 inclusive (8 days). A second EssenCES survey was conducted in each SMHRU approximately 21 months later: during the periods 25 March - 4 April 2022 (Caboolture) and 6-14 April 2022 (TPCH).

The same approach to conducting the survey was used on each of the four occasions. On the first day, the researcher visited the SMHRU and used the morning meeting with consumers and both the morning and afternoon staff handover meetings to brief staff and consumers about the survey and how to participate. In particular, the researcher emphasised that the survey was voluntary and anonymous; the survey form did not seek names, completed forms could be sealed into envelopes before being placed in the secure box provided, and only the researcher would see them. Several staff members and consumers took the opportunity to complete the forms then and there. Afterwards, piles of survey forms and envelopes were left in key locations within each SMHRU, together with the secure box. Several information sheets about the survey and how to participate were also left in conspicuous locations within each SMHRU. During the remainder of the survey period, staff were further encouraged to participate by the NUM in each SMHRU and by the RP Lead during their visits to TPCH SMHRU. Staff were also asked to encourage, and where necessary assist,

**Table 3: Outcomes study methods**

| KEY OUTCOMES EVALUATION QUESTION | PARTICIPANTS | DATA COLLECTION METHODS | ANALYSIS |
|---|---|---|---|
| **To what extent has the use of RP in TPCH mental health service achieved benefits for:**<br><br>**a) people who have been caused harm by TPCH mental health service consumers or staff**<br><br>**b) those who have caused that harm**<br><br>**c) other stakeholders, including TPCH SMHRU community as a whole?** | • Staff and consumers of TPCH SMHRU and the Caboolture Hospital SMHRU | • 2 paper-based surveys of social climate using the EssenCES, June 2020 and March-April 2022 | As prescribed by Schalast & Tonkin (2016) |
| | • SMHRU, Nundah CMH and Chermside CMH staff | • 3 structured online surveys about staff use of RP, with 'additional comments' option<br>— July/August 2020<br>— January/February 2021<br>— August 2021 | Descriptive statistics; thematic analysis |
| | • SMHRU staff, in-reach staff and consumers | • Semi-structured one-to-one interviews, January/February 2022 | Thematic analysis |
| | • Participants in restorative meetings | • Post-meeting questionnaires<br>• Structured telephone surveys<br>— 6 months post-meeting | Descriptive statistics; thematic analysis |
| | | • Request to Metro North Mental Health for pre- and post-implementation data on:<br>— incidents of harm within TPCH and Caboolture SMHRUs<br>— staff absences for non-recreation purposes<br>• Request to QHVSS for non-identifiable RP case management data | Descriptive statistics |

consumers to complete the survey form (some consumers needed assistance to read it), but were instructed not to complete it for them. At the end of each survey period, the box of completed survey forms was collected from the SMHRU.

**De-identified administrative data**

From Metro North Mental Health, a variety of de-identified administrative data on both TPCH SMHRU and the Caboolture Hospital SMHRU were requested for two 12-month periods — the period 1 March 2018 to 28 February 2019 (before the RP project commenced) and the period 1 March 2021 to 28 February 2022 (when the RP project was well underway). For each month in these two periods, data were requested on the number of:

- incidents where a consumer had caused or threatened to cause harm to a staff member
- incidents where a consumer had caused or threatened to cause harm to another consumer
- seclusion events (i.e., occasions when, usually for their own and others' safety, a consumer has had to be physically isolated from others in the ward)
- leave days taken by nursing and allied health staff for purposes other than recreation or mandatory isolation after close contact with someone diagnosed with COVID-19.

The latter data were sought on the assumption that high levels of sick leave can sometimes be indicative of poor staff morale, which might reasonably be expected to improve in a restorative work environment. Similarly, high levels of WorkCover leave in a SMHRU environment may be related to high levels of violence, which the RP project was, to at least some extent, intended to reduce.

Seclusion data may be indicative of levels of aggression and violence within a ward. Seclusion events are often voluntary (i.e., a consumer may request to be placed in seclusion because they feel they might become violent) and are expected to occur from time to time in a SMHRU. However, when they occur at a rate of more than 10 per 1,000 bed days, this may be a concern. That said, a high rate of seclusion events may be due to one consumer being secluded a number of times. Seclusion events are generally expected to last around three hours, but longer seclusions may occur.

The seclusion data on the Caboolture and TPCH SMHRUs provided by Metro North Mental Health included, for each month of the two 12-month periods, the number of seclusion events, the average length of those seclusion events, and the rate of seclusion per 1,000 bed days. The latter figure is calculated by dividing the number of seclusion events for the month by the number of bed days for the month. It was not possible to obtain data on whether the reported seclusion events were voluntary or involuntary.

Metro North Mental Health supplied data from the RiskMan database on incidents during the two periods 1 May 2018 to 28 February 2019 (10 months) and 1 March 2021 to 28 February 2022 (12 months) where a consumer had caused or threatened to cause harm to a staff member or to another consumer. However, because RiskMan was not established until May 2018, it was not possible to obtain data on such incidents for the period 1 March to 30 April 2018. For this reason, data for the alternative comparison periods of 1 July 2018 to 30 June 2019 and 1 July 2021 to 30 June 2022 were sought and obtained. (The very small numbers of incidents recorded in RiskMan during May and June 2018 suggested that mental health staff may not yet have been using the new database consistently in its early days.)

De-identified administrative data for the period 1 January 2020 to 31 March 2022 were also sought and obtained from QHVSS case management records, as follows:

- the number of referrals to facilitated restorative meetings
- the number judged not suitable
- the number of facilitated restorative meetings held
- the number of cases closed.

**Online staff surveys**

The three online staff surveys conducted for the process component of the evaluation (and described above) also sought information for the outcomes component. Specifically, the surveys asked how useful staff were finding RP as an option for responding to incidents where harm had been caused or threatened. Survey 1 asked only about incidents where physical harm had been caused or threatened, but Surveys 2 and 3 also asked about incidents where other types of harm had been caused or threatened.

**Post-meeting questionnaires**

Participants in facilitated restorative meetings held during the evaluation period were invited to complete one-page questionnaires seeking their views on the outcomes of the meeting and the extent to which they found it beneficial. Three slightly different structured questionnaires (Appendices 10-12) were designed for use immediately after facilitated restorative meetings: one for the person who had been harmed (14 items), one for the person who had caused the harm (15 items), and one for the support persons (15 items). Each questionnaire comprised a list of statements with which respondents were asked to indicate their level of agreement using a five-point scale, ranging from 'strongly agree' to 'strongly disagree'. Space was also provided below this list to enable respondents to write any additional comments they wished to make about the restorative meeting.

However, these three questionnaires were only used for one restorative meeting, which was held in October 2021 and facilitated by an external RP facilitator from ARJC. This was the only meeting that involved participants who clearly identified as a person harmed and a person who had caused the harm. The other three restorative meetings were initiated to resolve workplace grievances and were facilitated by the RP Lead. While they involved someone who felt they had been harmed, they did not involve anyone who was willing to identify, in the lead-up to the meeting, as someone who had caused that harm. For these three meetings, a generic questionnaire based on the three original questionnaires was developed at the request of the RP Lead (Appendix 13) for use by all meeting participants.

At the end of each of the four restorative meetings, the facilitator invited the participants to complete the relevant questionnaire, seal it into an envelope and return it to them. The sealed envelopes were then provided to the research team.

**Six-month follow-up telephone surveys**

At the end of the restorative meeting facilitated by the external ARJC facilitator in October 2021, the participants who had been involved in the harmful incident (i.e., the person who was harmed and

the person who harmed them) were asked to give written permission to be contacted about participating in a follow-up telephone survey (see consent form at Appendix 14). Those who agreed were contacted by telephone in mid-April 2022 (see script at Appendix 15) and interviewed in late April (see interview questions at Appendix 16). Those who completed the telephone survey were sent a $30 multi-store gift voucher to thank them for their time.

**One-to-one stakeholder interviews**

Semi-structured one-to-one interviews were conducted with TPCH SMHRU staff, in-reach staff and consumers during the period 24 January to 7 February 2022. These interviews asked participants about the outcomes of the RP project in the SMHRU, including outcomes for staff, consumers and the SMHRU as whole.

Staff and in-reach staff participants in the interviews were sought by several means. The NUM sent an email invitation to all SMHRU staff a few days before the interviews commenced, but most interviews were secured by means of direct approaches from the researcher, who was by this point in the evaluation well known to most staff. She liaised with the NUM to ascertain when staff who had been identified by the NUM and/or the RP Lead as key sources of information would be on duty. She then spent those days on site in the SMHRU, so that staff who were interested in participating in an interview could do so relatively easily if an opportunity arose during their shift. These site visits also proved useful in recruiting in-reach staff when they visited the SMHRU. In addition, the RP Lead sent email invitations to two in-reach staff members and one SMHRU staff member who was on a short secondment elsewhere. All three then contacted the researcher to arrange suitable interview dates, times and locations.

Informal agreements from staff to participate in an interview were followed up in all cases by the provision, either by email or in person, of copies of both the participant information and consent form (Appendix 17) — which participants were required to sign and return before their interview commenced — and the question guide (Appendix 18).

All but one of the interviews with SMHRU staff and in-reach staff were conducted in person at the participant's workplace; the other interview was conducted online using *Microsoft Teams*.

Potential consumer participants were identified in consultation with the RP Lead and nursing staff, taking into account the length of time they had been in the SMHRU, their familiarity with aspects of RP such as circles and restorative dialogue, and their current mental state. Consumers who were deemed suitable for interview were then approached by their allocated nurse and asked if they were interested in participating. They were also advised that, if they wished, a staff member could be present to support them during the interview, and one consumer chose this option. Consumers were required to read the participant information sheet and sign the consent form (Appendix 19) before the interview commenced. The consumer interviews were conducted inside the ward, using the question guide shown at Appendix 20. Participating consumers were each given a $30 multi-store gift card to thank them for their time.

The interviews with staff members and consumers ranged in length from 8 minutes to 46 minutes. With the agreement of participants, all the interviews were digitally recorded and professionally

transcribed. The transcriptions were then checked against the audio files and corrections were made as necessary before the data analysis commenced.

## Data analysis

### Process study

Workshop feedback data were analysed separately for each of the four workshops, following completion of each one. Responses to the structured items were entered into *Microsoft Excel* spreadsheets and descriptive statistics were calculated using *Excel*'s inbuilt analytical tools. Resulting statistics for each workshop were subsequently compared. Qualitative data from each set of feedback sheets were analysed for content and themes rather than on a question-by-question basis. A comparison of themes across all four workshops was not undertaken until after all four had been completed.

Similar processes were used to analyse the quantitative and qualitative data from the three online staff surveys; that is, data from each survey were analysed separately prior to any comparisons being undertaken. However, the quantitative survey data were analysed using the inbuilt analytical tools available in the 'Premier' version of *Survey Monkey*.

Thematic content analysis of the qualitative data from project documentation was undertaken progressively throughout the process study; this work informed the inclusion of probing questions during some of the stakeholder interviews and in some cases aided the interpretation of participants' responses.

Qualitative data from the first round of interviews were analysed prior to the second round commencing, using a coding framework that was progressively refined as themes and sub-themes emerged from the transcripts. A similar approach was adopted to code and analyse the data from the second round of interviews. Only after this work was completed was a comparison of the main themes from each round undertaken.

### Outcomes study

Of the 17 items on the EssenCES questionnaire, only 15 are scored. These items are short statements, to which respondents are asked to indicate the extent of their agreement, using a five-point scale (from 'not at all' to 'very much'). Responses are scored from 0 to 4, with higher scores indicating a more positive social climate. As there are five items for each of the three dimensions measured by the EssenCES, the maximum score for each dimension is 20 (Schalast & Tonkin 2016).

The completed EssenCES questionnaires were scored individually by hand, in accordance with the instructions in the EssenCES manual (Schalast & Tonkin 2016). Individual scores for each dimension of social climate were then entered into *Microsoft Excel* spreadsheets to enable mean values for each dimension to be calculated for each group of survey participants in each of the two SMHRUs.

The small quantities of de-identified administrative data for TPCH and Caboolture Hospital SMHRUs obtained from Metro North Mental Health were provided in *Microsoft Excel* spreadsheets. The data on incidents where Caboolture Hospital or TPCH SMHRU consumers had caused or threatened to cause harm to staff or other consumers comprised largely qualitative data on each incident, outlining

the circumstances and participants in each case. Analysis of this information allowed each incident to be categorised as either verbal aggression, threatened physical aggression or actual physical aggression. Incident counts for each category were then obtained and compared for the two SMHRUs and the two 12-month periods. Numbers in each category were too small to allow any more sophisticated statistical analysis.

The remaining data from Metro North Mental Health — on seclusion events and on staff sick and WorkCover leave — were analysed using *Excel*'s inbuilt analytical tools. Where appropriate, paired samples *t*-tests for statistical significance were conducted. The analysis sought to identify:

- any relevant patterns or trends, either negative or positive, that might be correlated with the RP project
- for each SMHRU, any differences between the 12-month periods from 1 March 2018 to 28 February 2019 — prior to the commencement of the RP project at TPCH SMHRU — and 1 March 2021 to 28 February 2022, when the RP project was well underway.

As for the process study, the quantitative data from the three online staff surveys were analysed using the inbuilt analytical tools available in the 'Premier' version of *Survey Monkey*. The small amount of qualitative data yielded by the final open-ended question in each survey were analysed first for relevance to the key evaluation question and then thematically.

This same approach was used to analyse the small amounts of qualitative data from the post-meeting questionnaires and the six-month follow-up telephone surveys. The raw quantitative data from these sources were entered into *Microsoft Excel* spreadsheets for descriptive analysis using *Excel*'s inbuilt analytical tools. However, the combination of small participant numbers and slight differences between the questionnaires made even such simple analysis challenging, and so the analysis ultimately focused on themes and patterns rather than numbers. The case management data made available by QHVSS provided some background information that informed the data analysis.

The three components of the key evaluation question, together with the themes identified in the other qualitative data, served as an initial coding framework for analysis of the transcripts of the one-to-one stakeholder interviews. This framework was progressively refined as coding continued and additional themes and sub-themes emerged.

# Results

## Participant characteristics

### Process study

The number of participants in each of the four three-day RP skills workshops who completed feedback forms is shown below in Table 4, together with their work areas. Note that, for Workshop 1, respondents were not asked to indicate their work area; however, the workplaces of about half of them were identifiable anyway because they wrote their names on the forms. Given that this workshop was primarily targeted to SMHRU staff and other mental health staff who worked with SMHRU consumers, it seems likely that most of the nine in the 'Other/unknown' category for Workshop 1 either worked in the SMHRU or were in-reach staff.

**Table 4: Respondents to workshop feedback form by work area**

| Work area | No. of respondents | | | |
|---|---|---|---|---|
| | Workshop 1 December 2019 | Workshop 2 July 2020 | Workshop 3 October 2020 | Workshop 4 May-June 2021 |
| **SMHRU** | 6 | 9 | 3 | 5 |
| **Nundah CMH** | 1 | 7 | 4 | 3 |
| **Chermside CMH** | 1 | 4 | 0 | 0 |
| **QHVSS** | 0 | 1 | 4 | 2 |
| **Other MH unit** | 6 | 5 | 6 | 4 |
| **Other/unknown** | 9 | 1 | 3 | 5 |
| **Total** | **23** | **27** | **20** | **19** |

Table 5 below shows the number of staff in each of the three teams who submitted completed surveys during each survey period, together with the response rates for each work area and overall. As explained earlier, the first survey was targeted only to SMHRU staff, while the third survey targeted staff from the SMHRU and Nundah CMH only. Some SMHRU staff may have responded to all three surveys, and many Nundah CMH staff seem to have responded to both Surveys 2 and 3, while Chermside CMH staff responded only to Survey 2. It should also be noted that the number of SMHRU and Nundah CMH staff to whom the survey link was sent by the NUM and team leader varied from one survey to another, presumably because of variations in staffing levels.

Across all three surveys, most respondents opted not to make any additional comments about the RP training, their experiences of using RP, or the value of RP in their work area. Four respondents to Survey 1, ten respondents to Survey 2, and nine respondents to Survey 3 offered such comments.

**Table 5: Completed online surveys submitted during each survey period, by work area**

| Work area | No. of completed surveys / response rate | | | | | |
|---|---|---|---|---|---|---|
| | Survey 1 July-August 2020 | | Survey 2 January-February 2021 | | Survey 3 August 2021 | |
| **SMHRU** | 13 | 45% | 14 | 45% | 14 | 35% |
| **Nundah CMH** | n/a | n/a | 14 | 82% | 13 | 68% |
| **Chermside CMH** | n/a | n/a | 9 | 43% | n/a | n/a |
| **Total** | 13 | 45% | 37 | 54% | 27 | 46% |

A total of 15 people, all from TPCH Mental Health, participated in the first round of stakeholder interviews. They included the two members of the QHVSS project team, four staff who provided in-reach services to the SMHRU, two members of the SMHRU allied health staff, and five members of the SMHRU nursing staff and two other SMHRU staff members.

Seven of the same people also participated in the second round of interviews, in which 20 stakeholders altogether took part. Participants in the second round again included the QHVSS project team, a member of TPCH Mental Health's executive team, three staff who provided in-reach services to the SMHRU, three SMHRU allied health staff, four SMHRU nursing staff members, one other SMHRU staff member, the Nundah and Chermside CMH team leaders, three other staff from Nundah CMH, and an RP facilitator from the ARJC team at the Department of Justice and Attorney-General.

**Outcomes study**

Altogether, 21 staff members and 6 consumers at TPCH SMHRU completed the baseline EssenCES questionnaire. Considerably fewer staff members (8) completed the second EssenCES questionnaire, while 5 consumers did so.

At the Caboolture Hospital SMHRU, 15 staff members and 8 consumers completed the baseline EssenCES questionnaire, and roughly the same numbers (16 staff members and 10 consumers) completed the second questionnaire. However, one of the consumer participants in the second survey skipped so many items that their questionnaire could not be included in the analysis.

As the EssenCES questionnaires were completed anonymously, few other participant characteristics are known. Both SMHRUs have similar staffing profiles, with a mixture of both male and female staff. In terms of consumer characteristics, however, the two SMHRUs are somewhat different: while TPCH SMHRU consumers are all male, Caboolture SMHRU consumers comprise both males and females. Furthermore, although no data were available to confirm this, anecdotal reports suggest the average length of stay for consumers in the Caboolture SMHRU is somewhat shorter than at TPCH SMHRU and that there may tend to be differences in the cognitive abilities of the two consumer cohorts.

The QHVSS data showed that 19 people were either referred by Metro North Mental Health staff or self-referred for potential restorative meetings during the study period. Of these cases, only four

progressed to a facilitated restorative meeting, and only one of these meetings was formally facilitated by an external (ARJC) facilitator. Of the remaining 15 cases:

- one — a recent referral — was still open at the time of writing this report
- one was on hold as the consumer was too unwell to participate
- one was resolved with an informal restorative meeting (no post-meeting questionnaires were completed)
- four were closed due to one or more of the participants declining to go ahead
- eight were deemed unsuitable for restorative meetings.

A total of 17 completed post-meeting questionnaires were collected from participants in the four facilitated restorative meetings held during the study period. Among the 17 people who completed questionnaires were three people who identified[4] as someone who had been harmed, one person who identified as someone who had caused harm and two people who identified as support persons for someone who had either caused harm or been the recipient of harm.

Only one person — a person who had been harmed — participated in a six-month follow-up telephone survey. Attempts were made to contact the other person who had participated in the formal restorative meeting, but they were not well enough to take part in a follow-up interview.

A total of 19 people participated in the one-to-one stakeholder interviews conducted for the outcomes study. They included 4 SMHRU consumers, 12 SMHRU staff (doctors, nursing and allied health staff) and 3 staff who provided in-reach services to the SMHRU.

## Findings

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

Answers to this question were drawn from the workshop feedback, the three online surveys and the two rounds of interviews.

A key part of the work undertaken by the project team to prepare the selected mental health services for the implementation of RP was the provision of three-day workshop training in RP skills for interested staff members. Feedback on all four of the workshops was overwhelmingly positive. While there were some differences in the feedback on each workshop (discussed below), the overall majority of participants who completed a feedback form viewed the training as relevant to their work and believed it would make a difference to the way they did their job (see Table 6). Although there were some neutral responses, across all four workshops only one participant expressed any level of disagreement with any of the positively worded statements about the relevance of the training to their work. Their responses to the open-ended questions on the feedback form indicate that this person had some prior knowledge of RP, so their disagreement with the statement *I developed new skills and strategies relevant to my work* could have been about the newness of the skills rather than the relevance to their work.

[4] Either by means of their additional comments or by their completion of a specific questionnaire for persons harmed.

**Table 6: Workshop participants' views on the relevance of the training to their work**

| Statement | Workshop | | Level of agreement | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | Strongly agree | Agree | Neutral | Disagree | Strongly disagree | |
| The training was relevant to my workplace needs. | 1 | Dec 2019 (n = 23) | 13 | 9 | 1 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 11 | 9 | 7 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 20) | 20 | 0 | 0 | 0 | 0 | 20 |
| | 4 | May-Jun 2021 (n = 19) | 13 | 6 | 0 | 0 | 0 | 19 |
| I developed new skills and strategies relevant to my work. | 1 | Dec 2019 (n = 23) | 18 | 5 | 0 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 9 | 16 | 2 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 20) | 17 | 3 | 0 | 0 | 0 | 20 |
| | 4 | May-Jun 2021 (n = 19) | 14 | 3 | 1 | 1 | 0 | 19 |
| I can see the potential for RP to be valuable in my workplace. | 1 | Dec 2019 (n = 23) | 16 | 7 | 0 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 12 | 11 | 4 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 20) | 19 | 1 | 0 | 0 | 0 | 20 |
| | 4 | May-Jun 2021 (n = 19) | 14 | 4 | 1 | 0 | 0 | 19 |
| The training will make a difference to the way I do my job. | 1 | Dec 2019 (n = 23) | 16 | 7 | 0 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 10 | 16 | 1 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 20) | 20 | 0 | 0 | 0 | 0 | 20 |
| | 4 | May-Jun 2021 (n = 19) | 14 | 2 | 3 | 0 | 0 | 19 |

Another noteworthy feature of Table 6 is the comparatively low level of agreement among Workshop 2 participants about the relevance of the training to their work. Of the four workshops, this one had the largest attendance of CMH staff (11), and CMH staff comprised six of the seven participants who were neutral about the relevance of the training to their workplace needs. In addition, many of the participants in this workshop used the open-ended questions to comment on the need for the training to be better tailored to the work of CMH teams. For example, one CMH participant commented that they would have liked *more mental health (community) examples … hard to relate school, prison and inpatient scenarios to our work*, and several others made similar comments.

As well as recognising the relevance of the workshop training to their work, the majority of participants across the four workshops expressed confidence about using RP skills in their work. For example, close to half of all participants strongly agreed with the statement, *I am confident I can use restorative dialogue in my work*, and none disagreed with it. As shown in Table 7, workshop participants also reported feeling confident that they could facilitate restorative circles in their workplaces. However, that confidence was less strong among Workshop 2 participants than among participants in the other three workshops — possibly because, as noted above, this group was less inclined to perceive the relevance of RP to their work. Note that the one person who disagreed with the statement, *I am confident I can facilitate restorative circles in my workplace,* was from QHVSS and included a comment that they were absent on the day that circles were discussed and practiced.

**Table 7: Workshop participants' reported levels of confidence in using RP skills in their work**

| Statement | Workshop | | Level of agreement | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | Strongly agree | Agree | Neutral | Disagree | Strongly disagree | |
| I am confident I can use restorative dialogue in my work. | 1 | Dec 2019 (n = 23) | 11 | 11 | 1 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 8 | 18 | 1 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 20) | 9 | 9 | 2 | 0 | 0 | 20 |
| | 4 | May-Jun 2021 (n = 19) | 11 | 5 | 3 | 0 | 0 | 19 |
| I am confident I can facilitate restorative circles in my workplace. | 1 | Dec 2019 (n = 23) | 7 | 14 | 2 | 0 | 0 | 23 |
| | 2 | Jul 2020 (n = 27) | 5 | 13 | 9 | 0 | 0 | 27 |
| | 3 | Oct 2020 (n = 19) | 8 | 10 | 1 | 0 | 0 | 19 |
| | 4 | May-Jun 2021 (n = 19) | 12 | 3 | 3 | 1 | 0 | 19 |

The usefulness of the training staff had received, if any, was also the subject of several questions in the three online staff surveys, and again the responses across all three surveys were mostly positive. Moreover, the responses suggest that SMHRU and Nundah CMH staff maintained their perceptions of the usefulness of their training over time. Table 8 shows the results of the three surveys, by work area, for the question, *How useful was the training* [you received] *in preparing you for the implementation of RP in your work area*? Respondents to this and subsequent questions about the usefulness of their training could have completed the half-day awareness session, a three-day skills workshop, or both; however, all had done at least some training.

**Table 8: Staff perceptions, by work area, of the usefulness of their RP training in preparing them for the implementation of RP in their work area**

| | Very useful | | | Moderately useful | | | Somewhat useful | | | Not at all useful | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 |
| **SMHRU staff** | 6 | 6 | 8 | 3 | 5 | 2 | 1 | 1 | 1 | 0 | 0 | 2 |
| **Nundah CMH staff** | n/a | 8 | 9 | n/a | 4 | 1 | n/a | 1 | 0 | n/a | 0 | 0 |
| **Chermside CMH staff** | n/a | 3 | n/a | n/a | 2 | n/a | n/a | 1 | n/a | n/a | 0 | n/a |

The amount of training survey respondents had done was not a reliable predictor of how useful they found it for preparing them for the implementation of RP in their work area. For example:

- the two SMHRU respondents to Survey 3 who had not found their training at all useful for this purpose had both completed a three-day RP skills workshop
- across all three surveys, those respondents who had done only the half-day awareness session all reported it to have been at least somewhat useful
- Surveys 1 and 2 each had two respondents who had done only the half-day awareness session but had nevertheless found it very useful in preparing them for the implementation of RP.

Table 9 shows the results when survey respondents were asked about the usefulness of whatever they had done in preparing them to use restorative dialogue in their work area. These results were again predominantly positive, showing a similar pattern to those reported in Table 8 above. Again, the amount of training survey respondents had completed was not a reliable predictor of how useful they found it. For example, one respondent to Survey 3 had attended only a half-day awareness session but had found it very useful in preparing them to use restorative dialogue in their work area. By contrast, the respondent to Survey 3 who had not found their training at all useful in preparing them to use restorative dialogue in their work area had attended a three-day skills workshop. More predictably, the respondent to Survey 1 who reported that their training had not been at all useful in

preparing them to use restorative dialogue in their work area was someone who had done only the half-day awareness session.

**Table 9: Staff perceptions, by work area, of the usefulness of their RP training in preparing them to use restorative dialogue in their work area**

| | Very useful | | | Moderately useful | | | Somewhat useful | | | Not at all useful | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 |
| **SMHRU staff** | 6 | 9 | 9 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 0 | 1 |
| **Nundah CMH staff** | n/a | 10 | 8 | n/a | 2 | 2 | n/a | 1 | 0 | n/a | 0 | 0 |
| **Chermside CMH staff** | n/a | 3 | n/a | n/a | 1 | n/a | n/a | 2 | n/a | n/a | 0 | n/a |

When asked about the usefulness of the training they had done in preparing them to use restorative circles in their work area, staff were again fairly consistently positive in their responses, as can be seen from Table 10.

**Table 10: Staff perceptions, by work area, of the usefulness of their RP training in preparing them to use restorative circles in their work area**

| | Very useful | | | Moderately useful | | | Somewhat useful | | | Not at all useful | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 |
| **SMHRU staff** | 7 | 8 | 6 | 1 | 3 | 6 | 1 | 1 | 0 | 1 | 0 | 1 |
| **Nundah CMH staff** | n/a | 2 | 7 | n/a | 7 | 2 | n/a | 3 | 1 | n/a | 1 | 0 |
| **Chermside CMH staff** | n/a | 2 | n/a | n/a | 2 | n/a | n/a | 2 | n/a | n/a | 0 | n/a |

Several other questions in the online staff surveys provided insights into how well staff in the three mental health service areas (SMHRU, Nundah CMH and Chermside CMH) were prepared for the implementation of RP. For example, staff who had completed at least some training were asked whether they would have preferred to have had more, less or about the same amount of training, while those who had completed no training were asked if they would have liked to have had some training. No clear patterns emerged from the responses. Overall, however, it seems that regardless

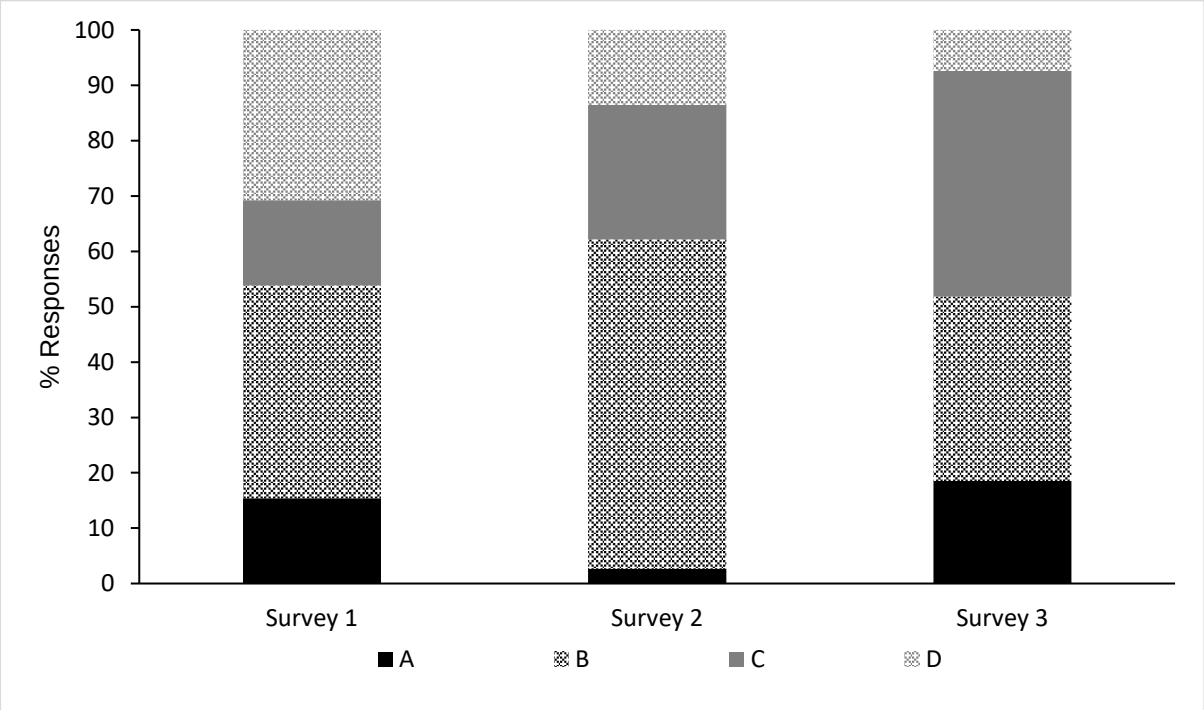
of the amount of training they had undertaken, about half of those staff who had done some training were satisfied that it was about the right amount.

Respondents to the three online staff surveys were also asked how confident they felt about using RP in their work areas. Their responses to this question, by work area, are shown in Table 11, while overall responses for each survey are shown in Figure 2.

**Table 11: Staff confidence about using RP, by work area, across the three surveys**

| | Very confident | | | Moderately confident | | | Somewhat confident | | | Not at all confident | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 | Survey 1 | Survey 2 | Survey 3 |
| **SMHRU staff** | 2 | 1 | 2 | 5 | 10 | 6 | 2 | 2 | 4 | 4 | 1 | 2 |
| **Nundah CMH staff** | n/a | 0 | 3 | n/a | 8 | 3 | n/a | 5 | 7 | n/a | 1 | 0 |
| **Chermside CMH staff** | n/a | 0 | n/a | n/a | 4 | n/a | n/a | 2 | n/a | n/a | 3 | n/a |

**Figure 2: Staff confidence about using RP in their work area, by survey**
**A = Very confident; B = Moderately confident; C = Somewhat confident; D = Not at all confident**




Just on half the respondents to Survey 1 were either moderately or very confident and by Survey 2 this proportion had increased to about two-thirds. By Survey 3, however, it had dropped back to half,

despite an increase in the number of respondents reporting feeling 'very confident'. Caution is needed in interpreting these changes, however, given the small numbers of respondents to each survey.

Of the 11 respondents to Survey 3 who reported feeling only 'somewhat confident' about using RP in their work area, 3 had done no training and 1 had done only a half-day awareness session. The other 7 had attended a three-day skills workshop, but 6 of them would have liked more training.

Few respondents reported feeling 'very confident' in any of the three surveys, but those feeling 'not at all confident' declined considerably over the three surveys. It should be noted that, in Survey 3, the two SMHRU staff who reported feeling 'not at all confident' about using RP in their work area included one who had completed a three-day skills workshop but would have preferred to have had no training and one who had done no training but did not want any. Their responses may have had less to do with their confidence than with their attitudes towards RP, which were revealed in subsequent survey responses. For example, to a later question in the survey — *Overall, how positive do you feel about the introduction of RP into your work area?* — both checked the response, 'I think the RP project is a waste of time and effort'.

The three online surveys all included an open-ended final item that invited additional comments, and a small number of the responses were relevant to KEQ 1, in that they commented on the high quality of the training provided. Some also echoed the comments of those workshop participants who had expressed disappointment that the training did not focus more on the ways in which RP could be used in CMH teams. For example, in Survey 2, one CMH team member commented, *It was unfortunate that the breadth of ideas for community teams was not evident at the time of the training* and suggested that discussion of these ideas during training would have enabled CMH staff to be better prepared for the implementation of RP in their work areas.

The third sources of data to help answer KEQ 1 were the two rounds of stakeholder interviews, during which participants were asked how well they felt the three service areas had been prepared for the implementation of RP.

Most participants in the first round of interviews — which focused only on the implementation of RP in the SMHRU — felt that they themselves had been well, or well enough, prepared. Not surprisingly, those who had been involved in the planning stages felt best prepared:

> *We'd had some initial discussions, and then we had that initial half-day training. Then we started having the regular meetings, and then I participated in the longer training… and then after that training, I felt fairly secure and able to come away and have at least a basic understanding of the model and RP in general, and then some of how it could actually be applied here in SMHRU* (P1).

Those who felt themselves to have been well prepared for implementation in the SMHRU also included some who had either done no training or done the three-day RP skills workshop only shortly before their interview. They commented positively on the amount of information they had received in the lead-up to implementation and on the fact that the RP Lead had spent considerable time in the SMHRU talking with them about the project and the RP model. During the first round of

interviews, one nursing staff member with no prior training acknowledged that they would have been better prepared if they had done the skills workshop, but nevertheless felt well prepared:

> *I mean, the kind of like posters and things around the place as well helped to kind of explain the process more. Because I think I've only ever been in like a small handover about Restorative Practice and actually what it is. But yeah, I think I was well prepared* (P2).

Another first round participant, an in-reach staff member who was able to attend only one day of the December 2019 skills workshop, commented, *I think I had a pretty firm grasp of the concept, even from that one day* (P3).

However, a few first round interview participants, particularly those who had done no training prior to the implementation of RP, felt that the information provided beforehand had not adequately prepared them for the practical application of RP in the SMHRU. For one nursing staff member, the relevance of RP to the SMHRU was:

> *Something that I kind of, I had trouble grasping because I think what a lot of people had in their mind is you have the victim and you have the perpetrator, then a lot of the nursing staff were thinking staff and patient, and you're sitting down and you're kind of having a discussion post-event and that a lot of the patients don't really have the mental capacity to kind of understand the process and what it was about or possibly wouldn't be willing to do that* (P4).

One SMHRU nursing staff member who participated in the second round of interviews observed that staff were as well prepared for the implementation of RP as they had been previously for the introduction of the mental health recovery model (which had been a significant change). While this participant felt that staff could have benefited from some pre-reading, they acknowledged that not everyone would have read such material even if it had been available.

> *I don't think anyone was terribly well prepared but some of us obviously looked at it prior to going* [to the training] *and some didn't, some wouldn't and are still rejecting it* (P16).

Another participant who had done the December 2019 skills workshop referred to the challenge of culture change in both rounds of interviews. They pointed out in their first interview that training and information may not be adequate preparation for the kind of change entailed in implementing RP in mental health services.

> *The training gives you a foundation, but doesn't really prepare you for that long-term change. It's not a change that happens overnight. We're talking about a lot of culture change. I think no training really prepares you for that process* (P5).

In regard to how well SMHRU consumers were prepared for the implementation of RP, the most common view was that they did not need — and would not necessarily benefit from — any specific training. In the words of one nursing staff member during the first round of interviews:

> *Sometimes I think they could be bamboozled by the explanation, especially if that's a fairly long-winded one and they might just think this is too much information and opt out* (P4).

The timing of any consumer preparation was also an issue to consider, as another first round interview participant pointed out.

> *It's a little bit difficult to introduce them to something when we can't support that. So you can't have them kind of involved in those early stages, because it's like they just can't manage that anticipation. …So I guess their preparation was probably quite limited, because most of the efforts went towards preparing staff, so that once we actually then introduced it with the patients, then staff could support that* (P1).

Most first round interview participants thought consumers were well enough prepared for the implementation of RP following the external RP trainer's visit to the SMHRU in December 2019, when she ran a restorative circle discussion with consumers.

> *I think they really enjoyed that, and I think that that has really set up then the sort of moving through the continuum further, the circles group, that type of stuff. …The way that I think it was introduced with* [the trainer] *coming, doing the introductory session and then us trying to then support that moving forward, I think was well done* (P6).

When asked how well they thought other staff were prepared for the implementation of RP in the SMHRU, first round interview participants most commonly referred to nursing staff attitudes, which they rarely perceived to be positive.

> *Look, I think it's tough because* [the RP Lead] *tried to prepare as much as they could, but the culture here isn't very accepting of all of this* (P3).

> *I think nursing staff were initially a little bit annoyed that they hadn't been more involved in some of the discussions. …Once we actually got down to the training, I think nursing staff were already kind of on the backfoot, going, 'What is this? Why are we doing it?'* [And also] *the background of some really serious assaults that had occurred over a much longer period … fed into how they feel about this. …they felt Exec was saying, 'Oh well, you guys aren't doing this well so here, here's another thing for you to do'* (P6).

> *Staff had a few issues, I suppose, because we did the training — the timing of the training probably wasn't the greatest in December, because we started our process, then the key people doing that process went into Christmas holidays. …so we didn't really have that — we lost a bit of momentum I thought* (P5).

> *There are perceived pros and cons for using it here… I wouldn't say they were very keen. I wouldn't say there was overall enthusiasm, but there was sort of reserved enthusiasm is the word, yes* (P4).

In particular, the half-day awareness sessions in June 2019, which focused more on facilitated restorative meetings than the full continuum of restorative practices, were perceived by first round interview participants to have contributed to negative attitudes among some SMHRU staff.[5]

> *I remember a lot of people went away from that thinking, 'Oh, this is too much. Not going to work. Forget it.' So all that hard work that* [the RP Lead] *did leading up to that just literally,*

[5] Note that while the scope of this evaluation does not include evaluation of the half-day awareness sessions, the negative responses to those sessions reported by participants in the stakeholder interviews were not consistent with the more positive feedback that was recorded by the project team at the time.

*within that one day, from what I saw, just — well, in a word, stopped. That — it just lost momentum, I guess* (P3).

*The initial session that we did really caused a lot of detriment to the project. Staff were very negative following that session. It did not have the impact that we wanted it to, which was very disappointing* (P6).

Similar comments about the negative impacts of the half-day awareness session were also offered during the second round of stakeholder interviews. Here it worth noting that, by their own account, those who had been involved in planning for implementation were still developing their own understanding of the RP continuum at the time that the half-day awareness sessions were planned and held. Both members of the project team acknowledged in the round two interviews that the RP project *evolved from being focused primarily on conferencing to having those range of other options, dialogue and those sorts of things*, particularly after August 2019 when they engaged with the external trainer who ran the three-day skills workshops. It was from that point that *there was a lot more fleshing out of the model that we'd written, to really incorporate some more of the restorative practice than* [we had] *necessarily put priority on before* (P14).

Several participants in the first round of interviews seemed to doubt whether staff and consumers in the SMHRU could have been better prepared. As one participant said, *I don't think there's too much that could have been done differently in terms of — I mean, this is a very new program… it'd be silly to think that it'd be perfect as soon as you bring it in* (P7). Others tended to frame their suggestions in terms of ideals that they acknowledged were not necessarily feasible in practice. For example, they suggested that:

- Ideally, all staff would have done the three-day skills workshop, although the project team wanted the training to be voluntary, in keeping with the principles of RP. Moreover, in practice it would have been difficult to organise all staff to do the training. In recognition of this, two interview participants suggested that the workshops could have been closer together in time — but also acknowledged that the COVID-19 pandemic had interfered with the training schedule.

- Perhaps more could have been done to prepare consumers, possibly with the help of the Recovery Assistants, although it was acknowledged that they spend limited time in the SMHRU.

- It would have been better to involve some SMHRU nursing staff earlier in planning the project, as soon as the SMHRU was identified as the site for initial implementation, although, in practice, their rosters might have made it difficult for them to attend meetings.

It was also suggested that a couple of SMHRU staff could have been trained earlier and become RP champions, so that other staff could see support for RP coming from within the SMHRU, rather than from external people only. This suggestion had actually been attempted: with the aim of building leadership support within the SMHRU ahead of implementation, the NUM and one senior nurse completed the three-day skills workshop as early as August 2019, together with the RP Lead. However, whatever momentum was gained from this was lost when there was a change of NUM a few months later.

Participants in the second round of interviews were asked essentially the same questions as had been asked during the first round, but this time the focus was on the implementation of RP across all three mental health service areas, not just the SMHRU. It was apparent by this time that implementation in the Chermside CMH team was not proceeding as well as the project team had hoped, and this prompted some comments about how that team might have been prepared better.

> *I think maybe we just needed to do a bit more groundwork about what exactly — who are the clients and what are the nature of the circumstances day to day. Because the feedback seems to be that they're reasonably ambivalent about* [RP]. *Some are reasonably keen. But that might only be a small number. So the wider group seem to be more ambivalent, particularly as it* [RP] *applies to clients. They seem more open to using group concepts internally and how the team operates maybe, for, say, case review or something. But the application — well anyway …* (P14).

The ambivalence referred to here was perhaps reflected in the fact that, according to the RP Lead, no Chermside CMH staff expressed interest in attending either the third or the fourth of the RP skills workshops. Moreover, only one Chermside CMH staff member agreed to be interviewed for the evaluation, despite several invitations being relayed to the team. According to that person, Chermside CMH staff had had no say in whether they were going to participate in the project and were not well prepared for the implementation of RP.

> *We weren't prepared, no. We were just told this is what we're doing. There was three sites being picked and we were one of them* (P15).

In terms of communication from executive level, Nundah CMH staff were not necessarily any better prepared.

> *I think probably the communication from executive in the beginning probably wasn't fantastic. Well, it wasn't fantastic because it didn't happen. Apart from 'Your team is participating in this project', yeah* (P17).

Nevertheless, the latter interview participant did not feel unprepared, and seemed comfortable with a level of uncertainty about how RP was going to work in a community setting.

> *I feel like I was prepared fairly well. The only unknown was I guess — and that was an unknown for everybody — was how it would be applied in a community team. I mean, that was the purpose for doing it. I think the training gave you what you needed to know to implement it, yeah.* [The RP Lead has] *been fantastic, having them here. That's like a dream to have a project officer actually sit in your team and do stuff* (P17).

Other Nundah CMH team members seemed to have similar attitudes regarding their level of preparation, and to recognise that implementation of RP in a CMH team was something of an experiment, one in which they were being supported by the RP Lead. For example:

> *I think the training was very good preparation. It was a good orientation to RP in general, but I think there wasn't much concrete guideline about how we'd use it in the community yet. I think that's because we were the first community teams to implement it. …So while I feel like I was orientated to RP really well, I didn't really get how it would apply in the community teams until*

> [the RP Lead] *started doing the Monday meetings and started to say, well this is what you can do* (P18).

> *We went in not knowing anything and we came out at the end of the three days with some immediate skills we could use. Like the* [lanyard] *cards and things like that. So I think that was really helpful, yeah* (P19).

By contrast, Chermside CMH team members seem to have extended their ambivalence about RP to the RP Lead, seeing them as more of an annoying presence in their space than an on-site resource to support their implementation of RP.

> *I think people just feel as though they're being harassed and railroaded. …if people want to speak to them, they'll come and see them. I don't think it's so much that they need to go and seek out people to stand there and it's almost like the seller at the door, banging on the door, trying to get you to buy something or convert to something or whatever* (P15).

These contrasting views are discussed further below, in relation to KEQs 2 and 3.

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

Answers to KEQ 2 were drawn primarily from the two rounds of stakeholder interviews, with some additional insights provided by the minutes of the RP Steering Committee and the RPSTs.

One significant implementation problem evident from the data relates to the preparation work discussed above, in that many staff across the three work areas in which RP has been introduced have struggled, to at least some extent, to grasp the relevance of RP to their work. This seems to be largely due to a common perception that RP is primarily about restorative meetings, a perception that — according to some interview participants — many staff gained during the half-day awareness sessions in mid-2019. This perception, as indicated above, also reflected the orientation of the project team at that stage. And in the SMHRU, combined with a belief that *a lot of our guys haven't got the capacity to empathise or understand the process or even feel that they've done something wrong* (P5), it initially led some staff to question the relevance and value of the RP project.

> *It was easy for us to fall into … only seeing that end process of* [the restorative meeting] *and I think that's what we all got hung up on. You know, how many of our clients are actually going to engage in that process? And that was a real barrier* (P20).

> *Some of them … unfortunately, they've locked onto that first lesson* [the half-day awareness session]*. Not the rest, but they've locked onto that one and can't get their heads off it. That's their argument all the time* (P9).

A member of the SMHRU RPST who participated in the second round of interviews believed that the idea that RP was primarily about restorative meetings had not always been dispelled by the three-day skills workshops and may actually have been reinforced by some early versions of the visual resources developed for the project.

> *I look at the poster that's up there now* [see Appendix 1]. *It's long and you can see that end is a blue box but it's separate … Everything else* [the proactive practices]*, that's over here. It was*

> *initially a step diagram, so it all looked like it was flowing down to that, so everything else was a part of that … So it very much gave us the focus that* [the restorative meeting] *is the end point, so everything is leading to that* (P20).

Even by the time of the second round of interviews (March 2021), this impression persisted in the SMHRU.

> *The messages that people are hearing is that this is an intervention, you have to do something, it's not as much of a more of a — this is more of a philosophy, I guess, around how we can do things differently* (P6).

As indicated above, several SMHRU staff expressed doubts during the first round of interviews as to whether RP would be appropriate for SMHRU consumers.

> *I think your main problem is going to be your — it's just your cohort of patients. It's going to be — you know, are they appropriate for some of the stuff? A lot of them are. Some aren't* (P9).

> *And because the patients are so hardened … by the language used so far and have been there for years on end, to change it a bit, it requires — It's just a habit, we've just all become so habitual with what we do, patients as well as staff, yep* (P11).

These doubts were rarely voiced by SMHRU staff during the second round of interviews, although two participants said they had found that RP was not useful with consumers who were acutely unwell. That said, one of them acknowledged that sometimes RP does work with such consumers: *I find that I have to tweak the statements to better suit their current needs, for them to work* (P23).

However, the CMH team member — again apparently thinking in terms of restorative interventions rather than proactive practices — observed that *one of the problems has been the most obvious people that come to mind …The problems that are the most obvious that it would be great to use RP are probably with the most difficult consumers* (P18).

Some participants in the first round of interviews suggested that the fact that the RP project was driven externally, and by someone who had not previously worked in public mental health services, made implementation more challenging and may also have contributed to the early negative attitudes among SMHRU staff. Indeed, the RP Lead reported finding the SMHRU a challenging environment in the lead-up to the first skills workshop. However, this challenge was largely overcome as they spent increasing amounts of time in the SMHRU each week and as more SMHRU staff were trained in RP.

> *As an external person who was trying to implement, I don't think there was necessarily, outside of myself trying to support implementation, I don't think there was a huge amount of leadership or internal preparation for staff or consumers* (P8).

> *Being on the ward has been massively helpful for that, for just trying to make myself available two to three days a week on the ward, to really just having those conversations one to one with staff to find out what is going on and talk about opportunities* [for using RP] (P8).

> *As more staff have been trained, this has really meant that they were trying RP in situations, they were bringing more discussions into handover and case reviews, they were trying out the*

> *questions, they were noting it in their systems, and they were open to talking to me and being welcoming to me* (P8).

By the second round of interviews, only two or three SMHRU staff apparently held strongly negative attitudes towards the project and other staff thought their influence was diminishing over time.

> *But that resistance has — because as the others have all got educated, their arguments don't make any sense any more* (P9).

> *I feel like those people are probably, yeah, they're probably a little bit quieter about their views. You might hear them every now and then saying something negative like, 'Oh not that RP, it's a waste of time', or something like that, but it's more flippant comments as opposed to anything else* (P1).

> *I think* [implementation] *is moving forward regardless. Yeah, I think it's moving forward regardless, actually* (P21).

Meanwhile, the Nundah CMH team had *various levels of buy-in, but — the people that are less interested aren't really vocally less interested*. *Yeah, so, they're not talking it down*. *So, we did the fishbowl and there were a couple of people here that aren't as interested and they still participated* (P17).

Among the Chermside CMH team, however, resistance to RP seems to have been more widespread and more vocal from the start. The belief that restorative meetings are the end point of RP, again combined with a view that most of their consumers would not be capable of participating in such meetings, may have contributed to this resistance and to the team's eventual withdrawal from the RP project. During the second round of interviews, one participant reported hearing from a Chermside CMH clinician that they did not see how they could use RP.

> *I think people are seeing it as it's this big in-depth thing that they have to go through, when in actual fact some of the principles of and the skills that we're using, in terms of the affective statements, the restorative questions, they can be used at any time in your case management role* (P6).

But while not recognising the relevance of RP to their work, it seems that Chermside CMH staff also held the somewhat contradictory view that they were already using the proactive RP skills in their everyday interactions with consumers.

> *I really think that everyone here is of the agreeance that restorative practice language and the way that we do things is really Mental Health 101. That's exactly what we do in our everyday practice. That's what university-level clinicians are actually taught to do in their communication modules* (P15).

Yet, as indicated below in relation to KEQ 3, it appears — admittedly on the basis of an interview with only one member of the team — that the Chermside CMH team has incorporated, to good effect, some of the RP skills that staff learned in the three-day workshops into their team meetings and case reviews.

One participant in the second round of interviews, in discussing the differences in the level of engagement in the RP project between the Nundah and Chermside CMH teams, commented *that there was buy-in from a consultant in Nundah initially and there was no such buy-in from the consultant from Chermside* (P25). They also echoed another interview participant in speculating that *I think that it's about the leadership style* (P25), but neither participant was able to identify what the differences in leadership style might be. From the accounts of the two leaders, it seems that both came away from the December 2019 three-day skills workshop feeling enthusiastic about RP, but while one team was infected with that enthusiasm, the other was not.

While the data are not helpful in understanding why the Chermside CMH team opted out of the RP project soon after the second round of interviews, it is clear that one of the challenges for the RP Lead was finding ways to work with them effectively up until that point. The barriers were multiple:

- Because the Chermside CMH team is located on hospital grounds, the RP Lead was unable to provide on-site support to them during several COVID-19 lockdown periods, when visitors were excluded from entry.

- When site visits were possible, the RP Lead was allocated space in a separate office from the team and *found it quite problematic to sort of get an 'in' … really, really challenging to get an 'in' and feel like I had a valid place to go and be there* (P8).

- The COVID-19 pandemic and resultant lockdowns led to a significant increase in workload for the Chermside CMH team: *our referral rate just went exponentially through the roof. It was ridiculous. Even now, we're still — our caseloads have never ever been so high ever* (P15). In this context, staff were unwilling to spend three days doing training *that they really didn't want to do, that it wasn't mandatory, that they're already thinking that we already do all of this stuff anyway … They just didn't see the point* (P15).

Other participants in the second round of interviews also commented on the lack of time being a significant barrier to the implementation of RP, both in the CMH teams and in the SMHRU, where one participant identified finding time as the biggest challenge.

> *The pressures on the staff are so immense generally … the training's increased over the years, the audits have increased, the paperwork's increased … people just rushing around trying to get things done and trying to do the best they can. I think sometimes things just get either left behind or just not focused on as much as you'd like* (P5).
>
> *I think the community teams are all — they're all stretched beyond their limit, especially COVID brought more business for us and there is no corresponding change in the resources* (P25).
>
> *I don't think it's anybody's fault. I think, there's no funding, people have been asked to do more and more, there's loads more documentation that people have to do. It's really time poor and they get these other things chucked on them, and I think some clinicians feel like it's just another thing they are being asked to do and they just can't* (P22).
>
> *That's been, I think, one of the biggest things, is trying to create the space to have the conversations. Like we were talking about this morning, the fish bowling, creating the space in our case review. There's case reviews not set up unfortunately to have a good conversation*

*around what you're doing even though that's where you're supposed to have it. Yeah, so, we really have to work really hard to be able to create a space to then go, 'Let's have a fishbowl', and then try and get people to buy into it* (P17).

Another significant barrier, according to several participants in both rounds of interviews, has been change fatigue, especially among long-term mental health service staff.

*I've been a mental health nurse for the best part of 30 years as well, and so I'm aware of some of the barriers that long-term staff have with new things coming in because, over two to three decades, something new comes in, something new comes in, something new comes in. …So then that becomes a barrier for staff that have worked for a long time in the area* (P20).

*They'd be, 'Oh, this is just another thing that they've given to us. And next year, it will be something else. …So why should I put the effort in now because they're constantly moving the spotlight?' That's something you hear from up here and it's something that myself I've experienced over the last ten years* (P5).

Participants in both rounds of interviews also referred to the significant challenges involved in achieving culture change in mental health services, particularly in a secure setting such as the SMHRU. For example, during the first round of interviews, the RP Lead commented that:

*Some of the attitudes of a lot of* [SMHRU] *staff, who I think potentially, and for risk reasons that are reasonable, had a lot of time been in the 'to' box* [of the social discipline window — see Appendix 3]*, it's a big challenge to get into the 'with' box with consumers a lot of the time. So, really staff culture change… that's been a challenge* (P8).

During the second round of interviews, several participants discussed this challenge at length, referring to the history of the SMHRU, the institutionalisation of consumers and the broader public mental health system of which the SMHRU is a part. In addition, they noted that most SMHRU consumers are *managed by the Mental Health Review Tribunal as well in terms of what can and can't be done with them at different times and just stages of leave and so forth* (P20).

*This is a very long-standing culture where we are authoritarian, where we are paternalistic, very risk-averse. So, you're actually going against the grain of what we are used to. It challenges all of these previous philosophies that we've had about how we do our job. Previously this has been the Secure Mental Health Unit, it hasn't been a rehab unit. So, even that change in itself has been very significant* (P6).

*The biggest barrier to* [RP] *here is getting around the fact that we were a secure — we have the word secure in our name, so we are a facility that locks people up. Getting away from that is very difficult. So we're locking people up for X, we're stopping their leave for X and it's all about this punitive approach where we're trying to look at a restorative model rather than a punitive model* (P16).

*I can't speak for them* [consumers]*, but I imagine that they would think, 'What am I going to get out of this?', like, 'What does this do for me?' Because I find that even with some activities, not necessarily this, but it's like if you participate, there's chocolates, but you have to*

*participate. It's not like coming on their own, you've got to have something that's there for them, so what do they get out of it? I think that's what they think* (P21).

*So, when you've got a system that is in the 'to' box and the 'for' box, and then you're asking clinicians to be in the 'with' box, it is very difficult, because the system itself doesn't support that 'with' thinking. So, how do you actually? So it's almost like there's bigger changes that still need to occur, in order to support this fully* (P6).

One CMH team member also touched briefly on *the clinician's dilemma … trying to do that really authoritative stuff, then we're trying to do this other thing that's all voluntary and nice* (P18). But they and a colleague also spoke about another aspect of public mental health service culture that, in their view, did not align well with RP — the belief that staff should remain 'professional' at all times and not display emotions or vulnerability.

*Like you know how — like in mental health they say don't make any personal statements or anything like that. Sometimes like in therapy that goes but here you say, 'I'm very pleased.' 'It affects me to see you how you are struggling with all these things.' Which is very true; we do get affected, but accepting that our — expressing your own vulnerabilities and everything is quite a challenging thing which may be perceived as different thing if people are not trained in the restorative language. So I won't say push-back, but lack of participation, because they don't know* (P24).

*Some people might see it as a sign of weakness, that we admitted that a staff member had been hurt by someone. Not physically. So this is more emotional… I think that some people, and in some ways, me too, would see that as sort of admitting — you're a professional and then you're admitting that someone has harmed you. Is that an appropriate thing to do when they're the patient? I guess it's harder when the harm is emotional. It's harder to — it's a bit more blurry* (P18).

A related challenge identified by one participant is that, in a situation where a nurse might have harmed a consumer in some way, a restorative intervention would not be possible: *They're not going to admit fault, because that looks bad for them* and would be against union advice. *I just feel that sometimes the nurses are reluctant to do it because of the union and things* (P3).

Another interview participant observed that *if anything is going to involve culture change or a change of practice, which is very difficult to achieve, you need those thought leaders* (P20). They speculated that the change of NUM in the SMHRU just before the first RP skills workshop might have exacerbated the challenges to the implementation. As mentioned earlier, the previous NUM had been expected to be one of the 'thought leaders' for the project. However, new NUM attended the first workshop — along with other SMHRU staff — within a week or so of starting work in the SMHRU and was not well placed to take on the role of thought leader while also finding their feet in the new position.

*The new Nurse Unit Manager also has the responsibility of trying to maintain calm and not wanting too much change at a time when* [they have] *come in. Not that* [they're] *a barrier, but* [they're] *trying to manage the ward over the longer term and establish* [their] *role with the staff in the ward* (P20).

In relation to culture change, the RP Lead expressed some frustration over the fact that it had not been possible to run a pre-implementation survey of mental health staff to ascertain their readiness for RP and help inform the implementation approach.

> *Basically* [it] *was a survey around culture change, and how do you feel about change, and how are you sitting at the moment? I think that would have been really helpful as trying to lead an implementation, having a much better base for understanding how people were feeling about change, because I think there's a backdrop that people had just had* [training in] *trauma-informed care. They were probably quite change averse, or change-fatigued* (P8).

Reflecting the comments of the two CMH team leaders, mentioned above, the RP Lead observed that the SMHRU was chosen by the executive team for the project *and there wasn't collaborative input, necessarily, from staff around that … around the purpose and reason for that* (P8). As one SMHRU staff member put it, *I don't want to sound like I'm being super critical, but I haven't really heard them say anything about it, personally, so I'm not really getting any kind of message from them* (P1). Moreover, while acknowledging the practical difficulties and time challenges entailed in getting executive leaders to attend a three-day workshop, the RP Lead commented that whereas the expectations were on staff to be using RP, *what I think the staff would like to see is that leadership were also demonstrating and role modelling restorative practice* (P8).

Some of the challenges arising from the COVID-19 pandemic have already been touched on above, but a few participants identified it as a major challenge for the project, not least because it interrupted the training program; ideally the four skills workshops would have been held within a much shorter timeframe. Additionally, however, the pandemic has been *just a good excuse for anything*, according to the RP Lead. They acknowledged, however, the *huge increase in workload that COVID brought, as well as the change in a variety of health-related restrictions and rules that people had to manage* (P8). These things in turn impacted on people's capacity to go offline for the training workshops, particularly in the SMHRU, where there is a 24-hour rostered workforce and backfilling of absent staff is essential.

Several participants in both rounds of interviews commented on resourcing challenges. Most of these comments were about the ongoing challenge of providing appropriate training to new staff. For example, while commenting on the difficulty of getting the medical staff trained, one participant pointed out that registrars are on six-month placements and therefore change constantly (see more on the issue of training new staff below, in relation to KEQ 5). However, the RP Lead's lack of time was also a significant resourcing challenge for the implementation project.

> *So the challenge is about needing those people in the* [SMHRU] *who have had more exposure, more interest, more leadership around it, to pick that up more while — so the issue is around* [the RP Lead's] *resourcing and time availability. And that it's reliant on one person, so that's a vulnerability* (P14).

> *I feel like I use my time pretty effectively to be on the teams, but I'm obviously a 0.7 position, and there's also the challenge that there is potential interest elsewhere in the project, which is really exciting. And I've got to walk that fine line between providing information to people and not getting too excitable about spending too much time doing something else. As well as, from*

*an administration perspective, there's a huge amount of follow-up that I need to be doing, the coordination of this … and yeah, there's never enough time* (P8).

A related issue was the difficulty, within Queensland's public health system, of navigating *all the different design processes, and who to go to*, and the lack of both suitable software for developing resources and the time to use it.

> *I wish I had better access, and better access to people, to help me make more visual resources. Not just the video stuff, but I feel like it's been so time-consuming just even making the question cards into an A5 little flip book, which I think would be a really cool resource* (P8).

> *I don't have the software to create some of the visuals. …If I had the software, I'm sure I could do some good work with it, but again I feel like that's me taking time that I am already in a deficit of time at the moment. But it's also a really important thing to do* (P8).

As word about the project has spread, interest from other mental health service areas has grown, so managing scope creep has proved to be another challenge. For example:

- A QHVSS client expressed interest in a restorative meeting with mental health consumer from another Hospital and Health Service. *Is this going outside the boundary? Is it going outside the project? But the Steering Committee agreed to offer and see how far it might be able to go. In a way I think it was also about testing the process* (P14).
- Some SMHRU staff have spent time on secondments to other mental health teams within Metro North Mental Health, and this has prompted interest in RP in those service areas. In one case, this led to a restorative meeting, in October 2021, between a consumer from another mental health team (not participating in the RP project) and a family member whom they had harmed. This was viewed as a positive development for the project, but it involved extra work by the RP Lead to introduce the consumer's treating team to the basics of RP.

Finally, the second round of interviews identified the following issues as challenges for the project.

- The RPST in the SMHRU is struggling to fulfil its support and leadership role, largely because attendance at meetings is inconsistent due to the shift-work environment and often does not include any *on the ground nurses, and they're the ones that should be there … because they're the ones that can give the true idea of what's going on* (P3). The recent decision to have one person each month take responsibility for championing the use of RP in the SMHRU is an attempt to overcome this problem.
- Within the Nundah CMH team, *Some people have commented that they don't — they think* [restorative meetings] *might be going beyond our scope of practice as well. I think that's a concern to some people. And it's a concern to me too, I think we need to try to keep, I don't know. In acute Queensland Health mental health, we're always trying to put up — you can't get in because of this and we shouldn't do more than this. You know, always trying to do the minimum because things are stretched. …So yeah, I think some clinicians have thought that's not really our role to be doing family reconciliation type activities. …So it's just finding the opportunity for RP but then making sure it's also within our scope of practice is a bit difficult* (P18).
- The October 2021 restorative meeting mentioned above highlighted a lack of clarity among QHVSS Victim Support Coordinators (VSCs) about their role in providing support to a person

who is engaging in a formal restorative meeting as the person harmed. According to the minutes of the September 2021 RP Steering Committee meeting, the VSCs felt uncomfortable that their role in such cases was not consistent with their usual role as clinicians providing victim support services. In particular, they were apparently concerned that, as clinicians, they — rather than the external RP facilitator — should have the final say in assessing whether or not the person harmed was ready to participate in a restorative meeting. This issue was discussed at the September 2021 RP Steering Committee meeting, following which the project team organised a meeting between the VSCs and the ARJC team, with the aim of allaying the VSCs' concerns. This led to the development of a draft work unit guideline for the VSCs in relation to their role in the restorative meeting process, together with a draft position description for the RP Lead. However, these documents remain in draft form at this point, to be finalised after consideration of an extension of RP to other mental health sevice areas.

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

Answers to KEQ 3 were drawn primarily from the two rounds of stakeholder interviews. However, comments offered by a few participants in the three online staff surveys provided some supporting evidence, along with the predominantly positive feedback on the four RP skills workshops — which several participants in both rounds of interviews identified as an aspect of the implementation that had worked well.

> *The training was really good. Yeah, not just* [the external RP trainer, who is] *fabulous, but* [the RP Lead] *and the other people involved in the training. I think for giving people an understanding of the skills, it was pretty good* (P17).

> *I really enjoyed it. It was really interesting and very interactive, and I think a lot of clinicians including me came away from that thinking really positively about RP. Yeah, it was good* (P22).

Participants in both rounds of interviews often identified the model in general as something that was working well. Enthusiasm for its compatibility with the rehabilitation aims of the SMHRU, with the mental health recovery model and with trauma-informed care was evident in many participants' responses. As one of the participants in the first round of interviews put it:

> *I love the model. I think it actually works excellent. I think that — and I've said this all along … It's very well aligned with what we already know, what we use on a day-to-day basis. … So it's an opportunity I think for us to use that reflective practice, to come at things from a different angle and it aligns with everything that the unit is doing as well, in terms that we're a rehab unit. We're trying to actually support consumers, capacity build with them. This offers that opportunity for them to have that equal footing with us, whilst still maintaining obviously our — the structured environment that we have to. But it also I think offers our staff an opportunity to think about things in a way that repairs relationships and role models to our consumers how to do things differently in the community. So I love it. I think it fits perfectly* (P6).

Some interview participants noted that the model has *something for everyone* (P18), so that, as one of the SMHRU nursing staff observed, *you can pick out of it what you think is going to work and I*

*guess you just use your clinical judgement for who it's going to work on* (P21). This aspect of the model seemed to be recognised even by some survey participants whose responses overall suggested some ambivalence towards the RP project. For example, one SMHRU respondent to Survey 2 commented that RP *does not fit the patients in SMHRU but elements of the training are working well clients use the circles for morning meetings which is positive.*

In addition, several interview participants commented positively on the usefulness of the RP model in relationships with not only consumers, but also colleagues, and one noted the benefits for staff morale.

> *So, to me, it actually provides a framework for how you interact on an everyday basis with your colleagues, with your consumers. It can be in your meetings, it can be used and adapted in every environment, the skills, anyway* (P6).

> *With the way that we've actually restructured our meetings and the way that we do our case reviews, it's definitely worked well there, because it's given us a way to bring order to a meeting. It's actually been really good because … it's not threatening. It's not intimidating … Everybody has a say in a non-judgemental environment. It's been really good like that. From my own managerial point of view and from the team's point of view when we have get-togethers and meetings and stuff like that, absolutely, it's been fantastic* (P15).

> *I think it's great. I think it's got so many applications as an individual, in your own life, to — as a team leader I can see so much stuff that you could use with the team and with each other. So much untapped stuff you could do with consumers* (P17).

> *It's a very proactive way of — I guess getting a resolution or an outcome and we haven't had that before because we certainly have a lot of — I guess, robust conversations about difficult clients that we've had and it goes nowhere. Like you do your RiskMan or — after an incident, you do a report and then that's the end of it. So I think we get that feel that it's not the end of it we don't have to forget about it; we've got that avenue to explore things. So I think that's helped the morale of the team* (P19).

The specific aspect of the RP model that was most commonly identified, in both rounds of interviews, as working well was the restorative circles. Interview participants who worked in the SMHRU were particularly enthusiastic about the use of circles in morning meetings with consumers. They noted, for example, that these were now embedded into the daily routine in the SMHRU and were often being run by the consumers themselves, who are *choosing the topics that we talk about* [and] *taking lots of the leadership* (P6).

> *They've definitely got the hang of it, and it's been really useful to observe that — because we've actually had quite a lot of new clients come in — how the other clients have actually brought the new clients on board and given them — I mean obviously it's in their own kind of way…, but it's that peer support that they give each other. That also makes me think well, has some of this practice actually — helping them to learn some of these skills and they're actually feeling more able to build relationships with other people* (P1).

> *There are some consumers I've never heard speak until we had the circles* (P3).

> [The circles are a] *really a big thing you can do in a ward like this to build that sense of community — and also having the staff join into the circles. It's not just consumers all isolated in a circle conversing with themselves. When you have the staff in the unit you sort of — you're breaking down those barriers* (P7).

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.

> *Doing the circle work, the check-in, check-out, that's — I can see that the team — it really works in bringing the team together* (P17).

> *It was very beneficial for us when we had an incident, and we had that circle group. Because I've never really realised that I was affected by it because I don't think about it. … Just have that discipline. But when it was done, the restorative practice, it's like, okay, I did have that suppressed emotions. I felt better after, yeah, actually* (P23).

One interview participant from a CMH team commented on how useful fishbowls were in case reviews.

> *Because we typically just use them* [case reviews] *as a bit of a debriefing session and don't get any actual good clinical information out of that. But when we've done the fishbowls, it's worked really well. We did one, I think last week or the week before, and we got a lot of good feedback even from our doctors and things, now they're getting their heads around it, that it's actually really helpful. ... So that's something that we're now planning for at every case review — like, before the case review, we're identifying someone that we want to fishbowl, so that's really good* (P19).

In addition, the affective statements and questions have been found to work well in helping to resolve conflict and calm things down, according to several interview participants from both the SMHRU and the Nundah CMH team.

> *For example, one of the patients was like screaming at me. I said, 'Don't scream because I can't think and I'm getting scared', and everything. So I think the person suddenly stopped and thought, 'Oh, what's going on here?' Like, you know, 'Why is…?' So I actually said that I am vulnerable as well. I can't think when you are screaming like that* (P24).

> *I like the questions. If anything goes wrong, like the other day one of them had a go at me about something and I used these* [pointing to the affective questions poster on the wall — see Appendix 2] *and we were able to resolve it and still keep our relationship, but it was a good way of just talking it out and understanding his point of view and why he reacted the way he did* (P21).

> *There's lots of day-to-day small incidents that take place here* [in the SMHRU]*, and I think particularly for those kinds of incidents, the restorative questions are really effective, because a lot of the clients here need that short, sharp intervention around something that's gone wrong* (P1).

One of the Nundah CMH staff spoke about a particular consumer who had been referred for a restorative meeting that had not gone ahead, and is *an example of someone who is quite difficult*, and described *the success we got out of it even though it didn't go all the way to the* [restorative meeting]:

> *I went through the questions, and I've actually been able to go through the questions with them lots of other — because they're always having conflict. So there's been heaps of other occasions where we've had really good discussions. Much more robust than I would have been able to have with them before and they've been much less defensive using those questions as they're getting used to them. So now their responses come more easily* (P18).

According to one of the allied health staff from the SMHRU, most consumers in the unit have a history of developmental trauma and emotional neglect, and little or no experience of psychological safety. Using the affective questions to take the emotion out of the discussion of an incident — focusing on what happened rather than why it happened — is helpful in building rapport and sense of emotional safety and is therefore supportive of therapeutic interventions. Another interview participant, a nurse from the SMHRU, made a similar comment: *I think that using the restorative practice is easier to keep those therapeutic relationships* (P21).

The practice framework, or social discipline window (see Appendix 3) was another aspect of the model that was identified by interview participants as working well for them. One of the SMHRU nursing staff talked about the practical benefits for consumers if staff operate in the 'with' zone rather than the 'for' zone, even though it is easier sometimes to work in the latter. Staying in the 'with' zone as much as possible, they proposed, can help de-institutionalise consumers, although they may be resistant at first because it means they might have to do a bit more for themselves. They are more used to staff doing things 'for' them or 'to' them; they may even perceive that they are being punished if staff try to do things 'with' them.

> *But when you explain to them why you're doing it, after they've learnt to do it and they're doing it, they seem to be more receptive to it all and happier doing it, when they realise you're not making them do it because it's a punishment. Or that … you want them to succeed, and they sort of take that on board* (P16).

Another interview participant who provides in-reach services to the SMHRU observed that explicit use of the social discipline window provides staff and consumers with a common language to talk about and reflect on how they engage with each other.

> *Having that common language or a new way for us to reflect and for the clients to reflect on how we engage is what's going to really make that difference* (P20).

Others also commented on the usefulness of the social discipline window for encouraging reflective practice and as a teaching tool.

> *I've actually found* [the social discipline window] *a really useful tool, and that's almost like a pseudo-supervision type scenario, where you can actually do some of that reflection with the staff and say, "Okay, so this has happened, this is how you handled it, which box do you think you're in? Well, you're in the 'to' box, but okay, maybe that was okay in the circumstance, and what are some of the subtle things that may have pushed it more to in the 'with' box?"* (P1).

> *I find it a valuable teaching tool for new Grads and staff from non-SMHRU areas to work 'with' the patient and avoid negative avoidable situations. Also directing staff to use RP when responding to challenging behaviours (both staff to staff and staff to patient) in a less confrontational and punishment-orientated manner, having constructive interactions to avoid repetitive negative interactions* (SMHRU respondent to Survey 3).

In both rounds of interviews, several interview participants from the SMHRU referred to the value of the other visual resources on display around the unit, as well as the prompt cards attached to their lanyards, which display the affective questions (see Appendices 1-4).

> *The posters are good because they're a visual reminder sometimes and if something happens, I do kind of look at them and the little* [lanyard] *cards we got given. So if something happens with my patient and I, I can use the questions* (P21).

> *The* [lanyard] *cards have been useful, because then you can actually use that when things do come up spontaneously, which they do — to help sort of work through and unpack whatever incident had happened… so it's like a handy tool to use for* [debriefing] *and hopefully for everyone to gain a bit of understanding* (P4).

> *The 'compass of shame', the clients respond really well to that. I've found that they really understood the concept very well.* [The external RP trainer] *did some informal sessions with them, where she talked to them about the 'compass of shame'. That resonated really well with the clients, and a lot of them took it on board, understood it and they can do a little bit of that self-reflection of where they are in that 'compass of shame'* (P1).

In relation to aspects of the model's implementation that were working well, most interview participants — other than members of the QHVSS project team — either made no comment or remarked on the value of the regular on-site support provided by the RP Lead. The following are example quotes from both rounds of interviews and from both SMHRU and Nundah CMH staff (as mentioned in relation to KEQ 2, the Chermside CMH team were not so welcoming of the RP Lead's presence on-site).

> [The RP Lead] *has been very approachable and we've been able take them any ideas, any questions and we've been able to have them answered in person on the spot. I think that has been hugely beneficial* (P12).

> *Just the fact that* [the RP Lead] *is here week in, week out, works really well. … Because there's so many things you do — that you go to training and you're all excited and then a year later, you kind of have to pull out the folder and go what was that again? But* [the RP Lead is] *keeping it up there* (P18).

> *Having* [the RP Lead] *here as a driver has helped, because I think with the daily slog of day-to-day stuff, we don't have enough hours in the day to do what we have to do anyway. Having someone behind you just to — with a primary focus of just the project really helps. I think we'd have got weighed down with it otherwise, and probably dropped it a bit more than we have, just because of the daily slog* (P5).

> *Having* [the RP Lead] *here kind of just keeping it in your mind and then being able to talk around we're doing this stuff with this consumer, and* [the RP Lead] *goes, 'Well have you thought about doing it in this way?' It's kind of — that's where a lot of those ideas have come out, so that's been really helpful* (P17).

The RP Lead, in both rounds of interviews, also highlighted this on-site support as something that was working well to support the implementation of the RP model — as did the Project Director.

> *Being on the ward and making sure those meetings continue, rain or shine, has been really important for the project. …Regularly meeting and regularly talking: what are we doing? What's working? What's not working? What can we do better?* (P8).

> *Having visibility of a lead facilitator in the workspace for the people implementing is really important. Having a person with credibility in restorative practice* [and] *an understanding of mental health issues. Having quite an open, transparent, collaborative approach in working with those clinicians* (P14).

Other aspects of the model's implementation that were identified by interview participants as working well were:

- the fact that RP has been introduced as a voluntary option: *I think the fact that we've not had it forced down our throat and told it's mandatory to use it, it's had a reasonable take up* (P16)
- having the external RP trainer visit the SMHRU after each of the skills workshops, to talk with consumers about RP: *the way she engaged with them was really good. Some of the tools she used, like the porcupine thing, the ball that opens and closes, is a real good visual technique that's really stuck with our patients. …So she's a definite asset* (P5).
- collaboration between staff and consumers in the design of resources: *being able to develop and collaborate in designing resources for that particular unit for their particular clients — so tailoring resources — that they own those resources in a way* (P14)
- the commitment of the project team: *because it is quite easy for people to give up. Put up their hand and say that – when there is no buy-in and a lot of stumbles. …* [But] *they are wedded to the model, they are committed to the concept* (P25)
- the involvement of TPCH Mental Health staff outside the SMHRU and the CMH teams (e.g., nurse educators, the Mental Health Resource Team, the Forensic Liaison Officer, the Mental Health Intervention Coordinator — among others): *because it's sort of building a scaffold, I think, where things are raised more, and sometimes things can get forgotten about, but then if you've got other people sort of propping things up, it's helpful* (P8)
- regular RPST meetings in the SMHRU (monthly) and the Nundah CMH team (fortnightly)
- opportunities for the project team to share ideas and resources with international teams that are implementing RP in mental and other health settings: *it's been good to have — to bounce ideas off, share knowledge or resources with those other people who are implementing it in a slightly different — even a lot different in terms of context. But the models are similar* (P14).

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

Answers to KEQ 4 were drawn from the stakeholder interviews, none of which elicited any ideas for potential improvements to the RP model itself. Nor did many interview participants — other than the RP Lead — offer suggestions for improvements to its implementation from this point onwards. The most common suggestions were for things that could perhaps have been done better or differently in the early days of the RP project. As might be inferred from the findings already presented, two of these suggestions were to omit the half-day RP awareness sessions and to make the three-day skills workshop training more relevant to mental health settings — both secure units like the SMHRU and community settings — by incorporating more examples of the use of RP in such settings.

In relation to the latter suggestion, however, one participant in the first round of interviews expressed the view that stronger emphasis on the fact that the RP project was a first for mental health services in Australia might have encouraged more buy-in from staff during the period leading up to and immediately following the first three-day skills workshops.

> *I don't think that message has been well enough received either, that this is brand new ground. …Like I don't think that has been sold enough to say this is brand — we're ground-breaking here. There's not enough examples of it being used in mental health, because nobody does use it in mental health. So we don't have the examples, because it's not here yet and using that as a 'this is us, you know, driving brand new practice'* (P6).

Another participant suggested that it would have been helpful if the December 2019 workshop — which was targeted to staff who worked in or provided in-reach services to the SMHRU — had concluded with *a really proactive planning session of how we were going to come away and implement that in SMHRU* (P1). Similarly, another SMHRU staff member thought *it would have been better if we'd sat down as a group and set some goals at the start. …Looked at it and said, 'Right, what do we want to achieve in the first three months?'* (P5).

Other suggestions that were also made with the benefit of hindsight and similarly related to up-front planning included the following.

> *A clearer plan and timeline of what we were going to roll out and when, maybe from much earlier on, so that staff could see, okay, this is what RP is; some of us don't really know that much about it yet, but this is the process that we're going to go through, and this is when we'll be provided with education, and this is when we'll start implementing things* (P1).

> *We should have had — you know, before the actual training and things like that — we would have had a couple of meetings with all staff, myself included, and not just from the project people* [from QHVSS] *but perhaps some of the trainers would have come and then we would have had the framework. If they were given that broader framework and then, what this concept is about and how this has been applied in different settings. What were the reasons? And what we are going to do here? Then probably challenging ourselves, about, Do you think there's a role for this here? How do you think it can be applied in this environment? So that*

*kind of questioning perhaps would have — like we all brought in on the same platform in that journey at that time* (P25).

*Probably having more of a concept of what we're trying to do, before the training, would have been helpful. Because I think we went to the training and didn't — I mean it was great. Really interesting training. But we didn't really know what we were supposed to do with it straight afterwards* (P18).

Consistent with comments on problems the project had encountered, several interview participants observed that the implementation might have been less challenging had all interested staff completed the three-day skills workshop within a shorter timeframe, and perhaps if the roll-out of the training had focused on one team at a time: *It's like anything, it's about having your critical mass to help you drive it* (P17).

In addition, the need for stronger leadership involvement in the implementation of RP was mentioned often during interviews. Among some SMHRU staff who participated in the first round of interviews, more leadership from the NUM and the nurses in charge of shifts was suggested as a key to encouraging more consistent and robust use of RP. By the second round of interviews, most of the shift-leaders had been trained, and the perceived need was for more strategic leadership of the implementation in the SMHRU.

*A bit of a stronger direction, perhaps, in terms of maybe our consultant and our NUM, to go, 'Okay, now that we all know what's happening, we know how to use these techniques now, let's be more strategic. Let's make time in this meeting and this meeting and we will actively discuss this topic and this topic.' It probably needs to come from them now to just actually do some of that real practical implementation* (P1).

Also needed in the SMHRU, according to several interview participants, was someone other than the RP Lead whose role it would be to champion RP.

*I mean someone who is in morning meeting, for example, who is constantly thinking about things from an RP perspective. …Somehow or other we've got to translate away from* [the RP Lead] *being that person and translate that more and embed that more in the team* (P6).

In CMH teams, one interview participant proposed that having *the team leaders and the consultants being introduced to the same restorative principles at the same time would have led to more implementation of these* (P25). However, this person also cautioned against repeating the two-hour condensed introduction to RP that had been presented at a regular consultants' meeting.

*I think trying to condense it in two-hour session just took everything out of it and people were just sort of, you know, not getting the concept and then it confused people a little bit. …You need time to understand and then you gradually develop, imbibe that knowledge. I think the groundwork* [provided during the three-day workshop] *is very important* (P25).

As might be inferred from their comments on problems the RP project had encountered, several stakeholders thought more active involvement and leadership from the executive team was necessary, particularly given that the implementation of RP involves culture change.

> [The executive team] *really need to do the training first. I don't know if they did and just didn't listen. …But I'm not sure they got the culture of it. If you stand up in front of a group of clinicians and say, 'We want you to use this, this is wonderful', you've got to understand what you're talking about* (P18).

> *What I think the staff would like to see is that leadership were also demonstrating and role modelling restorative practice* (P8).

During the second round of interviews, both the two CMH team leaders remarked on the potential value of using some aspects of the RP model in executive meetings.

> *It could be so useful at that executive level in terms of the team leaders and executive. I could see fishbowls being so useful in executive meetings* (P17).

> *I think it would work perfectly when we have like executive meetings … to make everybody be a little bit more connected and have a say* (P15).

The RP Lead, during their second interview, described a variety of planned or wished-for improvements to strengthen the implementation of RP in the SMHRU and the Nundah CMH team — improvements that they believed would also help to ensure its sustainability. These are outlined below, in relation to KEQ 5.

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

Stakeholders' views on what is needed to ensure the sustainability of RP in TPCH mental health services were sought only during the second round of interviews. However, the final question on the workshop feedback sheet — 'What else is needed to support the use of Restorative Practice within TPCH SMHRU or CMH teams?' — could be interpreted as a similar question to KEQ 5. Most commonly, those who responded to this question suggested that one or more of the following would be required.

- Ongoing support and resources — particularly in the form of coaching, mentoring, on-site assistance and active promotion of RP, such as the RP Lead had been providing
- More staff trained — including two suggestions along the lines of *train every staff member in MHS including cleaning/admin/security* and one comment that RP *needs to be standard practice across mental health. Won't work as an optional add-on.*
- Follow-up / refresher training — particularly for community teams, to help them identify opportunities to incorporate RP into their work
- Active involvement of TPCH Mental Health executive team — including four comments to the effect that the executive team should be *actually physically doing it, not just saying it*
- A community of practice — including four suggestions for *bringing group together to talk about how things going, successes, areas for improvement/challenges*
- Top-down culture change within TPCH Mental Health.

While most of the above suggestions were put forward relatively early in the project, they were largely echoed by participants in the second round of interviews. For example, most participants believed the project had not yet reached a point where it would be sustainable without the involvement of someone whose job it was to continue championing the use of RP.

> *It's going to take some time. If* [the RP Lead] *wasn't here ... I don't think we'd still naturally just think oh, we can do a bit of an RP approach to that* (P19).

> *You need a driver behind it, or it will fall over, like everything, unfortunately. If it's not on someone's radar, they won't do it. …Unless it becomes their culture, their proper practice, it just won't get done. You need a driver* (P3).

> *Probably they are not ready yet at this stage. …it is fine now because no single person is responsible within the team. It is* [the RP Lead] *who is doing that. But that will die once* [the RP Lead] *leaves* (P25).

At the same time, 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, even without someone driving them. However, their optimism was usually qualified, with the sustainability of these elements of RP acknowledged to be dependent on the constancy of factors such as leadership support, staffing and visual reminders about RP.

> *The NUM at the moment is interested in it, the allied health are, it has the majority of the CNs on board and the majority of the new staff and existing staff are using it. …If the posters stay up and the reminders stay up for it and the circles continue, I can't see why it wouldn't* [be sustainable]*. Unless there's a big staff shift or something, I can't see it falling off myself.* (P16)

But as several interview participants observed, some significant staff changes were imminent in the SMHRU due to looming retirements. Further, the Nundah CMH team experienced a change of team leader during the project. Moreover, even the above participant who *can't see it falling off* suggested the need for some kind of driver or coach to ensure the sustainability of RP.

> *One of the big things that would work, or could work, would be someone on shift occasionally who could reflect back to people and say, you could have done that differently. Like, 'You did this, but have you thought about doing this?'* (P16)

> *A mentor that's available so you can talk to someone and say, 'Listen, this has come up'. An outside party where you could say, 'Listen, this has come up, what — is there a better way I could have handled this?' Because sometimes it is difficult.* (P16)

Some participants favoured internal drivers — one person in each team who, in the absence of the RP Lead, would take on responsibility for actively encouraging the use of RP.

> *Maybe it needs to be one person who has really got that responsibility and who is that known resource so that everybody is getting the same information from one person consistently all the time* (P1).

However, others saw this as impractical, mainly because of high existing workloads and competing priorities.

> *Maybe if someone on the team sort of takes up the mantle of being the RP person in the team. But the trouble is* [the RP Lead] *gives a lot of their time to organising things and your colleague wouldn't necessarily be able to do that* (P18).

> *Champions are great sometimes, but we have champions of other stuff and stuff gets dropped because if I've got to do this task, that task and that task, this is patient care and this is an audit that I have to get done or care plan that's got to be done to do this, they're going to take priority every time and then I think great having champions but champions need the time separate from their normal duties* (P5).

For this reason, some SMHRU staff suggested that the role of 'RP champion' should be a rotating one, with staff members taking it on for a month at a time — and this idea was adopted shortly after the interviews were conducted.

> *Even if that changes month to month, so even if you have just one person for a month who's the RP, who just is — their responsibility is to bring up RP-focused questions and even if we move that around. Because we're all trained in RP now, we all know it. So, it's about not having the onus on one particular person, because it can get really draining, I think. I think having — constantly being that positive voice all the time is also very exhausting* (P6).

Most interview participants also echoed workshop participants' suggestions for ongoing training in RP as a way to ensure its sustainability in TPCH mental health teams. Regular (annual or biennial) refresher training was a common suggestion, for example.

> *We need to keep the integrity of what it is that we're trying to do. …I think we need either once yearly, or once every two years, we need to go back and do a refresh on — a one-day-er where you just touch on each of the things* (P6).

> *Booster training type events. Maybe annually. Would keep it up in people's minds and focus on the really practical aspects of what you do in community mental health every day* (P18).

> *You'd still need ongoing training, like even refresher or developmental, some developmental processes for the people involved* (P26).

The RP Lead had some specific ideas for training resources that would help ensure the sustainability of RP. For example, they discussed the need for more visual resources *that are short and bitey … to help cement what we're doing. That could potentially be a series of videos that are all related to our continuum* (P8). Another suggestion, one that *would be a hugely time and resource consuming thing to do … would be to create some really good online content.* The RP Lead acknowledged that RP is *not a thing that can be taught just by reading about it or online, and it's a really participatory way of working*, but also noted that *one of the big things for staff is that they don't really feel like they can have three days offline; that's really challenging for them*. Thus an online course that could be completed in small chunks during shifts might help to reduce the length of time required to be spent in face-to-face training. As many other interview participants commented, given that staffing changes inevitably occur within all teams, ongoing access to high quality training for new staff is necessary if RP is to be sustainable in TPCH mental health services over time. Indeed, a few participants suggested that such training in RP should be mandatory for new staff. This might be viewed as incompatible with the principle that RP should be voluntary, but those who offered this suggestion speculated that the training could be mandatory even if the use of RP was not. Moreover, for the SMHRU to achieve the goal of becoming a 'restorative ward', most if not all staff would need to at least have RP as part of their toolkit.

> *Maybe that could be something like when someone starts new in the SMHRU, they have like a checklist they go through and check, yes, you've been shown where the toilet is, but you've also been shown or told about RP. So the idea is they come into there knowing the expectation is it's a restorative place, so this is the expectation that you're doing* (P3).

> *So part of that then is whether it gets to a point where it's seen as part of the service model. Of the way SMHRU operates within a service model. It articulates an element of restorative practice. Therefore if you're going to work there, we expect you to be using some of the restorative practice stuff. And there is an expectation you could use — you can use it or you could use it at some point if needed. …If they've signed up to say — yeah, this is what we do. This is what it means for us as a ward* (P14).

The same kind of thinking was apparently behind the suggestions from a few interview participants that something about RP could be incorporated into:

- Supervision sessions: *I was even thinking like some element of supervision around, How is it working? What's going on?* (P6)
- Performance and development plans: *I think that's important too, to say as part of — within those units anyway. If the unit or team has signed up to the process, then how people are using it* (P14).
- Policies and guidelines: *I think some of the team practices could definitely be put into some of the policy and — like an expected — even a work unit guideline or something could become an expected set thing like with debriefs or with fishbowls. They could be actually written into this is what's expected at a case review. So that would be one way of making it stay even if staff moved or leadership changed in the teams* (P18).
- Induction processes: *When people are inducted into the unit, 'Here is the session on restorative practice. Here's the cards we use. Here is some short videos you can watch. I'll support you to do this.' That sort of idea* (P14).

As the latter participant acknowledged, however, this suggestion — along with the many suggestions for refresher training and additional visual resources — comes back to *resources and confident, trained people to be in the unit, to continue to run with it* (P14). For this reason, another interview participant emphasised the need to shore up funding for the RP initiative over the longer term.

> *It does, it does require resourcing and that's just not cheap to do but I guess you're talking about the quality of the outcomes that the process can deliver* (P26).

The same participant, together with a few others, also emphasised the need to allow time for RP to become firmly established as 'the way we do things around here', especially given the extent of culture change required.

> *Sometimes you need to have, or you need to persevere with something for long enough for it to become embedded, for it to become mainstream, for people to start familiarising themselves in the practice and enjoying some successes along the way* (P26).

Finally, several participants in the second round of interviews echoed the suggestions made by some of the workshop participants in arguing 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.

> *Maybe the other thing too is from executive as well, that higher up management. If it's an agenda for executive and if it's aligned to KPIs and things like that then again, you're going to get more buy-in and you're going to get more sustainability, because I think the implementation has been relatively bottom-up. Which is fine, you can definitely do a successful bottom-up implementation of things, but you do have to at some point get top-down input as well and the two do have to come together* (P1).

**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?**

Answers to KEQ 6a were drawn from the post-meeting questionnaires and from the one six-month follow-up telephone survey completed by a person who had participated in a formal restorative meeting. In addition, one of the SMHRU staff members who participated in the stakeholder interviews used part of their interview to discuss their experience of participating in a restorative meeting as the person who had felt harmed.

Because of the small numbers involved, 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. For example, the three people who had been or felt they had been harmed all indicated agreement or strong agreement with all the statements on their post-meeting questionnaires, including strong agreement with the statement, 'The meeting was valuable for me personally.' The support person for one of these people also strongly agreed that 'The meeting was valuable for the person I supported.'

All three of the people who had been or felt harmed also strongly agreed that they would recommend a restorative meeting to others in similar situations. In addition, these participants all offered written comments, which were also resoundingly positive and included the following extracts.

> *Without this process I would not of had the space to talk about how I have been affected … such as the impact it has had on my physical health and lifestyle, and effects it has had on my family*.

> *Felt able to talk. It is definitely a good outcome for both parties to vent and then to be able to work together without grudges.*

> *This will help my future relationship with* [the person who harmed me]. *I am so appreciative, thankful and grateful for this opportunity.*

In the follow-up telephone interview, the participant in the formal restorative meeting who had been harmed selected strongly positive responses in relation to almost all aspects of the meeting,

which they described as *just a lovely experience*.[6] They also offered additional comments to most of their responses, emphasising their satisfaction with both the meeting process and its outcomes. For example, when asked how helpful it was to be able to talk directly with the person who harmed them about the impact of the incident on them, this person chose the 'very helpful' response and then added, *It was really, really helpful*.

Similarly, when asked to what extent they felt that participating in the restorative meeting had helped them recover from the harm that was done to them, the participant selected 'a lot' and then added that the meeting had helped them *put things in perspective and to move on*. And when asked how satisfied they were, overall, with the meeting outcomes, they answered 'very satisfied' and added that it was *just brilliant*. Finally, they answered that they would be 'very likely' to choose to go through a restorative meeting process again if they were involved in another incident in which they were harmed by someone else, and 'very likely' to recommend restorative meetings to others in such situations. They explained these answers by adding that *part of the healing process is getting your story out there*, especially to the other person, and that they had found this *very powerful, more so than I thought*.

Another of the three people who had felt or been harmed also participated in the one-to-one stakeholder interviews. During their interview, they spoke in more detail about the experience of participating in a facilitated restorative meeting following a series of harmful incidents where they had felt insufficiently supported by the Clinical Nurse and other staff on duty.

> *We all sat in a circle, and it worked, it did. We both aired our views, put it that way. There was no holding back. … Yeah, how do I feel about it now? It did work and … we're talking. I think without the restorative practice, I would have left. Or it would have just gone bigger, and bigger, and bigger. Do you get what I mean? But I think the restorative practice done, it was amazing… it all come out* [and] *like with the CN, I'm completely fine with* [them now] (Participant 33).

**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?**

Again, because of the small number of facilitated restorative meetings held during the study period — and the even smaller number of people who were willing to identify as a person who had caused harm — there are limited data on which to base an answer to KEQ 6b. However, the post-meeting questionnaires completed by the consumer who caused harm and their support person, together with the latter's unsolicited follow-up feedback emailed to the project team, indicate that the use of RP has been beneficial for that consumer.

Responses to the post-meeting questionnaires indicate that the consumer who had caused harm found the restorative meeting valuable for them personally, and their support person strongly agreed that this was the case. In their email feedback, the latter stated that the consumer had *advised it was a really positive and helpful experience and could not speak more highly of being*

[6] The exception was the question about how fair they thought the agreement that came out of the meeting was on the person who had caused the harm. The participant was not sure about this, because they felt they might have had more say in the agreement than the person who had harmed them.

*offered this intervention*. The support person also noted that both parties to the harmful incident (who were family members) now had a positive relationship, with the person who had been harmed now engaged in the consumer's recovery and advocating for them.

The consumer in this case also agreed to the following statements in the post-meeting questionnaire:

- The meeting allowed me to tell my story about the incident.
- I now understand the impact of the incident on the person I harmed.
- I take responsibility for what I did.
- The meeting will help me to avoid repeating the behaviour that caused harm.
- I would recommend a restorative meeting to others who have cause harm to someone else.

Two of the participants in the one-to-one stakeholder interviews talked about the benefits of an informal restorative meeting in which they had been involved. One was a nursing staff member who had been the subject of a complaint by a consumer, which had included a request for an alternative nurse. The other was a support person for the consumer who complained. The nursing staff member reported that they had benefited from the experience and believed it had also benefited the consumer.

> *So I apologised. I gave him my reasons* [for saying what I did]. *He listened to that and he understood at that point that maybe* [there was some basis for what I said]. *He accepted my apology and he said, 'Oh, maybe I should listen to you more about what I should be doing, as my nurse. …So it went very well and I think* [the RP Lead] *was very good at facilitating how it happened and I felt good after it, and I think he did too. So I think it was of benefit for us. Otherwise we wouldn't — we just would have walked off and just not aired our issues* [and there would have been a bit of] *'bad blood'* (Participant 36).

> *But that particular event, I reflected upon it and learnt that RP — it could have been handled differently and — but so it — well, obviously it's doing with, rather than to or for. So it allowed me to reframe my strategies to bring him around to thinking about what he* [was doing] *and the consequences of that. So it was good* (Participant 36).

The interview participant who had been the consumer's support person gave a similar account of the effect of the meeting on the staff member who had caused the harm. As they reported:

> *The staff member was able to acknowledge and go, 'Oh, okay, I didn't realise that I made you feel that way and I'm going to try to work on that for myself, because' — and it was a first time that it had been identified for them that the way that — the language that they were using or the way that they were speaking was making the individual feel really minimised in themselves … and that's why they were responding with more aggression* (Participant 28).

**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?**

Answers to KEQ 6c were drawn from a range of sources:

- the two surveys of social climate in TPCH and Caboolture Hospital SMHRUs
- the administrative data relevant to the two SMHRUs that was obtained from Metro North Mental Health
- the three online staff surveys about RP use
- the post-meeting feedback sheets submitted by restorative meeting participants who identified as neither a person who had been harmed nor a person who had caused harm
- the one-to-one stakeholder interviews with SMHRU staff, consumers and in-reach staff.

**Surveys of social climate**

Mean scores at June 2020 and March-April 2022 in each of the three dimensions of social climate measured by the EssenCES are shown below for consumers, staff, and consumers plus staff in each of the two SMHRUs. Table 12 shows the results for 'Patients' cohesion and mutual support', while those for 'Experienced safety' and 'Therapeutic hold' are shown in Tables 13 and 14 respectively. They suggest an overall negative impact of the RP project on the social climate of TPCH SMHRU, compared with a slight improvement — mainly in the dimension of 'Experienced safety' — in the social climate of Caboolture Hospital SMHRU. However, these results should be interpreted with caution, taking into account the following points.

- As noted earlier, the EssenCES has not been sufficiently tested to enable confidence that it is sensitive to changes within wards over time.
- Also noted earlier are the differences between the two SMHRUs. TPCH SMHRU has only male patients, while Caboolture SMHRU has both males and females; the length of stay at the latter tends to be shorter than at TPCH SMHRU; and there may be some differences in terms of consumers' cognitive abilities as well.
- The Caboolture SMRHU also had a change of NUM a few weeks before the first survey, a change that may be reflected in that SMHRU's results from the second survey. A change of leadership could reasonably be expected to affect a ward's social climate.
- Both sets of scores for the second survey are likely to have been affected by the multiple lengthy lockdowns that each SMHRU experienced between the two surveys as a result of the COVID-19 pandemic. Lockdowns that keep visitors out or prevent patients from taking leave could reasonably be expected to negatively impact a ward's social climate.
- The results for TPCH SMHRU may not be comparable due to the small number of staff who completed the second questionnaire (n=8), compared with the first (n=21). That said, the poor response among TPCH SMHRU staff to the second survey may in itself be an indicator of that ward's social climate (Schalast 2022).
- While similar numbers of TPCH consumers completed a questionnaire on each occasion (n=6; n=5), this group's scores in the two surveys may not provide sufficiently reliable assessments of social climate. Schalast and Tonkin (2016) suggested that seven to ten completed questionnaires per group per ward should be sufficient for a reliable assessment.

Although this has not been fully tested, fewer than seven completed questionnaires seems unlikely to be sufficient.

- Perhaps most importantly, the results of the EssenCES surveys are inconsistent with the evidence from other data collected and analysed for this evaluation.

**Table 12: Mean scores for 'Patients' cohesion and mutual support' in TPCH and Caboolture SMHRUs**

| Group | Mean scores for 'Patients' cohesion and mutual support' | | Change |
|---|---|---|---|
| | June 2020 | March-April 2022 | |
| TPCH SMHRU consumers | 11.92 (n = 6) | 9.20 (n = 5) | - 2.72 |
| Caboolture SMHRU consumers | 9.13 (n = 8) | 11.89 (n = 9) | + 2.76 |
| TPCH SMHRU staff | 10.43 (n = 21) | 11.63 (n = 8) | + 1.2 |
| Caboolture SMHRU staff | 11.07 (n = 15) | 10.44 (n = 16) | - 0.63 |
| TPCH SMHRU consumers plus staff | 10.76 (n = 27) | 10.69 (n = 13) | - 0.07 |
| Caboolture SMHRU consumers plus staff | 10.39 (n = 23) | 10.96 (n = 25) | + 0.63 |

**Table 13: Mean scores for 'Experienced safety' in TPCH and Caboolture SMHRUs**

| Group | Mean scores for 'Experienced safety' | | Change |
|---|---|---|---|
| | June 2020 | March-April 2022 | |
| TPCH SMHRU consumers | 11.71 (n = 6) | 8.65 (n = 5) | - 3 04 |
| Caboolture SMHRU consumers | 10.88 (n = 8) | 12.33 (n = 9) | + 1.45 |
| TPCH SMHRU staff | 9.48 (n = 21) | 10.63 (n = 8) | + 1.15 |
| Caboolture SMHRU staff | 8.33 (n = 15) | 9.88 (n = 16) | + 1.55 |
| TPCH SMHRU consumers plus staff | 9.97 (n = 27) | 9.87 (n = 13) | - 0.10 |
| Caboolture SMHRU consumers plus staff | 9.22 (n = 23) | 10.76 (n = 25) | + 1.54 |

**Table 14: Mean scores for 'Therapeutic hold' in TPCH and Caboolture SMHRUs**

| Group | Mean scores for 'Therapeutic hold' | | Change |
|---|---|---|---|
| | June 2020 | March-April 2022 | |
| TPCH SMHRU consumers | 10.67 (n = 6) | 8.60 (n = 5) | - 2.07 |
| Caboolture SMHRU consumers | 11.50 (n = 8) | 11.25 (n = 9) | - 0.25 |
| TPCH SMHRU staff | 16.33 (n = 21) | 15.75 (n = 8) | - 0.58 |
| Caboolture SMHRU staff | 16.27 (n = 15) | 16.50 (n = 16) | + 0.23 |
| TPCH SMHRU consumers plus staff | 15.07 (n = 27) | 13.0 (n = 13) | - 2.07 |
| Caboolture SMHRU consumers plus staff | 14.61 (n = 23) | 14.61 (n = 25) | 0 |

**Metro North Mental Health administrative data**

Data for the Caboolture Hospital and TPCH SMHRUs on recorded incidents of consumer aggression towards staff in the two 12-month periods 1 July 2018 to 30 June 2019 (Time 1: before the RP project commenced in TPCH SMHRU) and 1 July 2021 to 30 June 2022 (Time 2: when the RP project was well underway) are presented in Table 15 below.

**Table 15: Recorded incidents of consumer aggression towards staff in TPCH and Caboolture SMHRUs for the 12-month periods July 2018 to June 2019 (Time 1) and July 2021 to June 2022 (Time 2)**

| SMHRU | Caboolture | | TPCH | |
|---|---|---|---|---|
| **Type of aggression** | **Time 1** | **Time 2** | **Time 1** | **Time 2** |
| Verbal aggression | 3 | 5 | 1 | 5 |
| Physical aggression — threatened | 12 | 15 | 1 | 9 |
| Physical aggression — actual | 0 | 9 | 0 | 1 |

It appears from the above table that, in both SMHRUs, incidents of consumer aggression towards staff were more frequent in Time 2 than in Time 1, and that during both periods, such incidents tended to be less frequent in TPCH SMHRU than in the Caboolture Hospital SMHRU. On that basis, the RP project would appear to have had no effect. For several reasons, however, some caution is needed in interpreting these data, and the possibility that the introduction of RP has actually had a positive effect on the incidence of consumer aggression towards staff in TPCH SMHRU should not be excluded.

- Given the low numbers of recorded incidents during Time 1, some level of under-reporting from both SMHRUs seems likely during that period — most probably because, as mentioned earlier, the RiskMan database only came into use in May 2018 and staff may still have been becoming accustomed to using it.
- It may also be the case that individual SMHRU staff members vary in terms of how likely they are to report incidents of consumer aggression. It seems likely, for example, that more 'hardened' SMHRU staff would be less likely than newer or less experienced SMHRU staff to report incidents of consumer aggression, particularly where actual physical violence is not involved.
- The figures for TPCH SMHRU during both periods seem to contradict its history of violence, mentioned earlier in this report.
- It seems reasonable to expect that incidents of consumer aggression towards staff would have increased at least somewhat in both SMHRUs during Time 2, as a result of COVID-19 restrictions.

Table 16 shows the data for the Caboolture Hospital and TPCH SMHRUs on recorded incidents of consumer aggression towards other consumers in the two 12-month periods July 2018 to June 2019 (Time 1) and July 2021 to June 2022 (Time 2). This table shows a different pattern to that in Table 15, with the reported incidence of verbal aggression and threatened physical aggression reducing in both SMHRUs from Time 1 to Time 2, while the reported incidence of actual physical aggression increased, again in both SMHRUs. However, while the pattern is different, it is no less difficult to

interpret in any conclusive way. The points listed above are similarly applicable to these data, and they should be interpreted with caution.

**Table 16: Recorded incidents of consumer aggression towards other consumers in TPCH and Caboolture SMHRUs for the 12-month periods July 2018 to June 2019 (Time 1) and July 2021 to June 2022 (Time 2)**

| SMHRU | Caboolture | | TPCH | |
|---|---|---|---|---|
| **Type of aggression** | **Time 1** | **Time 2** | **Time 1** | **Time 2** |
| Verbal aggression | 2 | 1 | 7 | 1 |
| Physical aggression — threatened | 9 | 5 | 9 | 4 |
| Physical aggression — actual | 3 | 9 | 5 | 15 |

Tables 17 and 18 present the data on seclusion events in the Caboolture and TPCH SMHRUs during each month of the two 12-month comparison periods — the period 1 March 2018 to 28 February 2019 (Time 1) and the period 1 March 2021 to 28 February 2022 (Time 2). These tables show:

- the total number of seclusion events for each month
- the monthly rate of seclusion events per 1,000 bed days, with rates greater than 10 shown in red
- the average length, in hours, of each month's seclusion events, with averages greater than 3 hours shown in red.

It is evident from the two tables that during both 12-month periods, seclusion events were much more frequent in TPCH SMHRU than in the Caboolture SMHRU, and that, in the former, both rates of seclusion events and average lengths of seclusion events were often above the levels considered acceptable, particularly during Time 1.

Both SMHRUs experienced lower rates of seclusion events from Time 1 to Time 2. However, the improved seclusion rate at TPCH SMHRU was statistically significant from Time 1 ($M$=15.43, $SD$=142.49) to Time 2 ($M$=5.28, $SD$=21.06), $t(11) = 0.01$, $p < .05$ — depicted in Figure 3 — whereas the improvement at Caboolture SMHRU was not significantly different from Time 1 ($M$=1.50, $SD$=3.55) to Time 2 ($M$=0.48, $SD$=0.74) $t(11) = 0.053$, $p > .05$.

**Table 17: Seclusion events in Caboolture and TPCH SMHRUs March 2018 to February 2019**

| SMHRU | Seclusion events | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Caboolture Mar 2018 to Feb 2019** | Number | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 2 | 3 | 0 | 0 | 0 | **0.75** |
| | Rate per 1,000 bed days | 2.1 | 0 | 0 | 2.1 | 2 | 2.1 | 0 | 3.9 | 5.8 | 0 | 0 | 0 | **1.50** |
| | Average length (hours) | 2.7 | 0 | 0 | 1.5 | 2.8 | 5.8 | 0 | 2.4 | 3.2 | 0 | 0 | 0 | **1.54** |
| **TPCH Mar 2019 to Feb 2019** | Number | 10 | 7 | 4 | 3 | 7 | 2 | 0 | 3 | 22 | 14 | 19 | 12 | **8.58** |
| | Rate per 1,000 bed days | 19.7 | 15.0 | 7.9 | 5.8 | 11.6 | 3.4 | 0 | 4.9 | 38.1 | 24.4 | 31.4 | 21.9 | **15.35** |
| | Average length (hours) | 13.0 | 10.5 | 20.1 | 2.3 | 4.0 | 2.3 | 0 | 4.7 | 4.1 | 5.7 | 5.2 | 6.4 | **6.52** |

**Table 18: Seclusion events in Caboolture and TPCH SMHRUs March 2021 to February 2022**

| SMHRU | Seclusion events | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Caboolture Mar 2021 to Feb 2022** | Number | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | **0.25** |
| | Rate per 1,000 bed days | 0 | 1.8 | 0 | 0 | 0 | 1.8 | 0 | 0 | 0 | 2.1 | 0 | 0 | **0.47** |
| | Average length (hours) | 0 | 3.0 | 0 | 0 | 0 | 1.5 | 0 | 0 | 0 | 2.1 | 0 | 0 | **0.55** |
| **TPCH Mar 2021 to Feb 2022** | Number | 9 | 2 | 2 | 1 | 5 | 4 | 6 | 1 | 1 | 0 | 4 | 1 | **3.00**** |
| | Rate per 1,000 bed days | 15.1 | 3.5 | 3.4 | 1.7 | 8.5 | 7.1 | 11.2 | 1.8 | 1.8 | 0 | 7.3 | 2.0 | **5.28**** |
| | Average length (hours) | 4.6 | 2.7 | 2.6 | 3.0 | 3.5 | 2.2 | 4.7 | 14.7 | 5.5 | 0 | 4.8 | 2.8 | **4.26** |

** $p$ <.05

**Figure 3: Rates of seclusion events per 1,000 bed days in TPCH SMHRU for the 12-month periods March 2018 to February 2019 and March 2021 to February 2022**

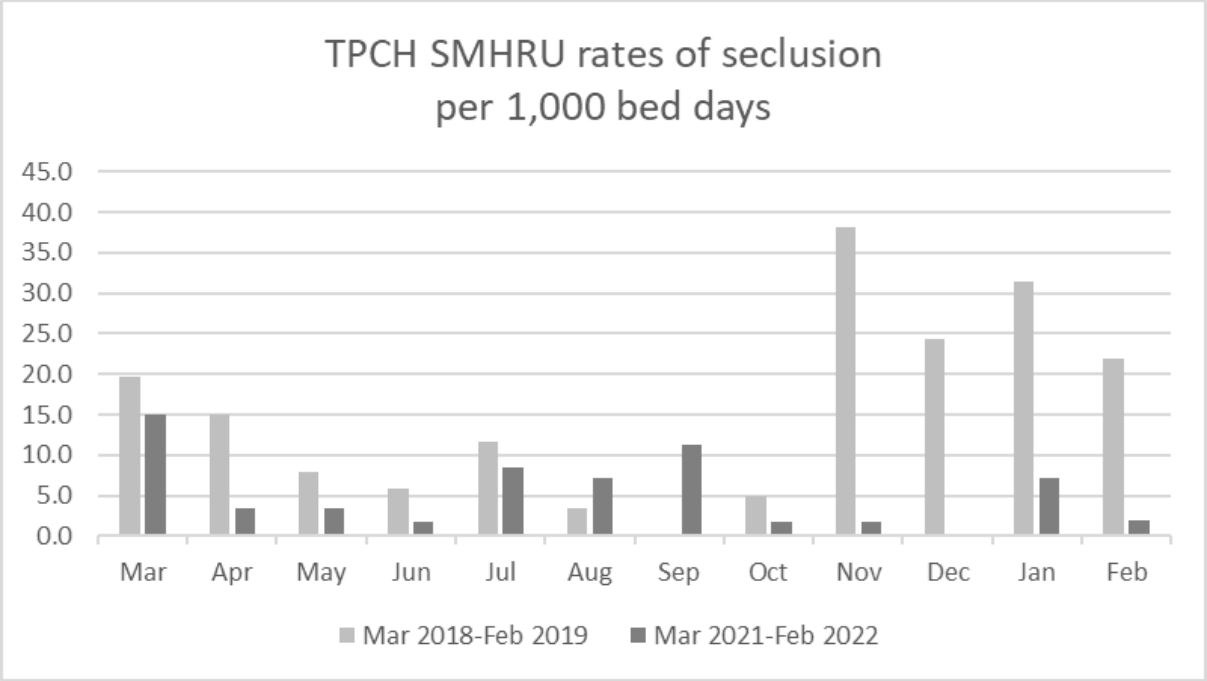
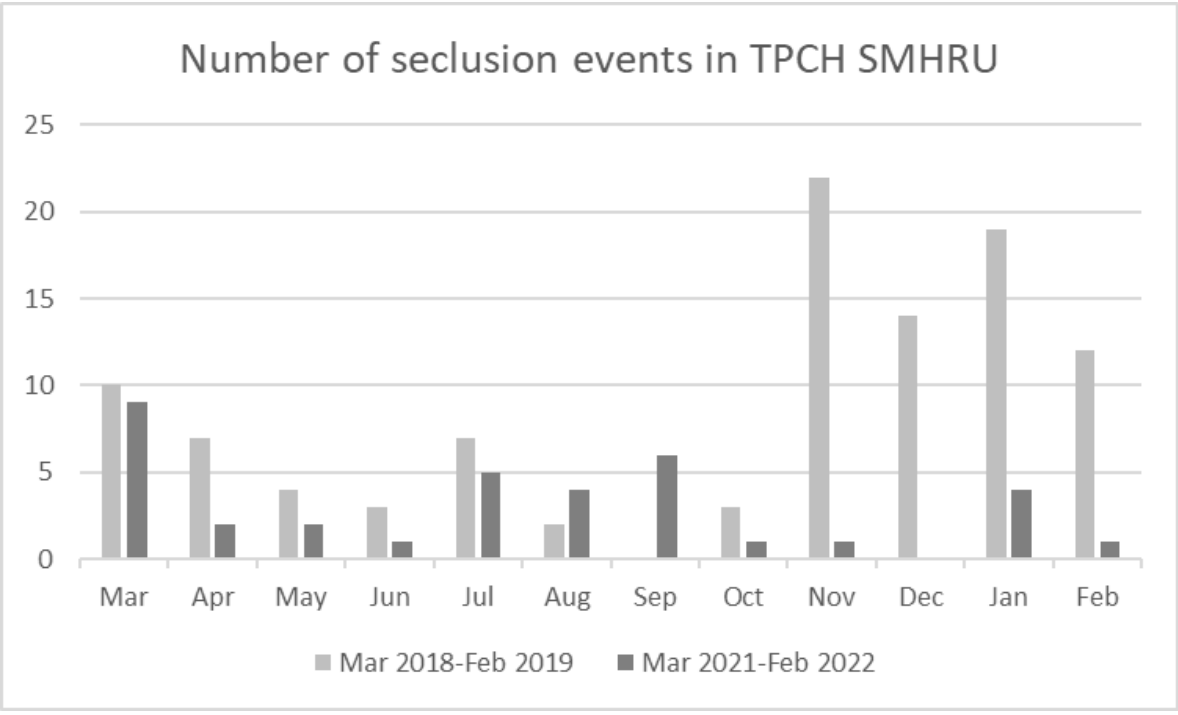


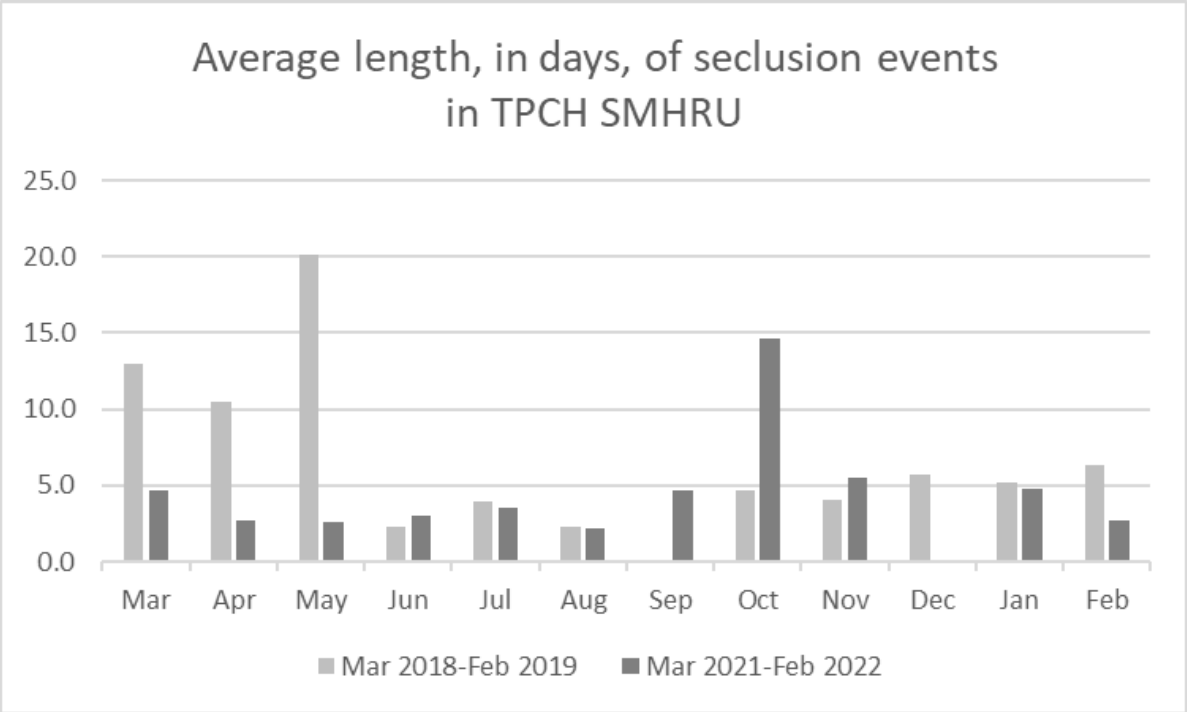

Figure 4 shows that in the 12-month period March 2021 to February 2022, TPCH also experienced a decrease in the number of seclusion events, compared with the period March 2018 to February 2019. This improvement was also statistically significant from Time 1 (*M*=8.58, *SD*=48.81) to Time 2 (*M*=3.00, *SD*=7.09), $t(11) = 0.011$, $p < .05$.

**Figure 4: Number of seclusion events in TPCH SMHRU for the 12-month periods March 2018 to February 2019 and March 2021 to February 2022**



While the length of seclusion events in both SMHRUs was shorter, on average, in Time 2 than in Time 1, the difference was not statistically significant in either SMHRU. That said, Figure 5, which shows the average length of seclusion events in TPCH SMHRU for each month in the two periods, highlights that the average for October 2021 was much higher than for any other month in Time 2. Further investigation of this potential outlier showed that removing it from the calculation produced a significant result, $t(10)$ 0.044, $p$ <.05 and suggests that a future evaluation of the length of seclusion events may confirm a reduction.

**Figure 5: Average length, in days, of seclusion events in TPCH SMHRU for the 12-month periods March 2018 to February 2019 and March 2021 to February 2022**




The number of sick leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs during each month of the two 12-month comparison periods is shown below in Figures 6 and 7. The total number of sick leave days taken by the same groups of staff in each of the same 12-month periods is shown in Figure 8.

**Figure 6: Sick leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs each month from March 2018 to February 2019**

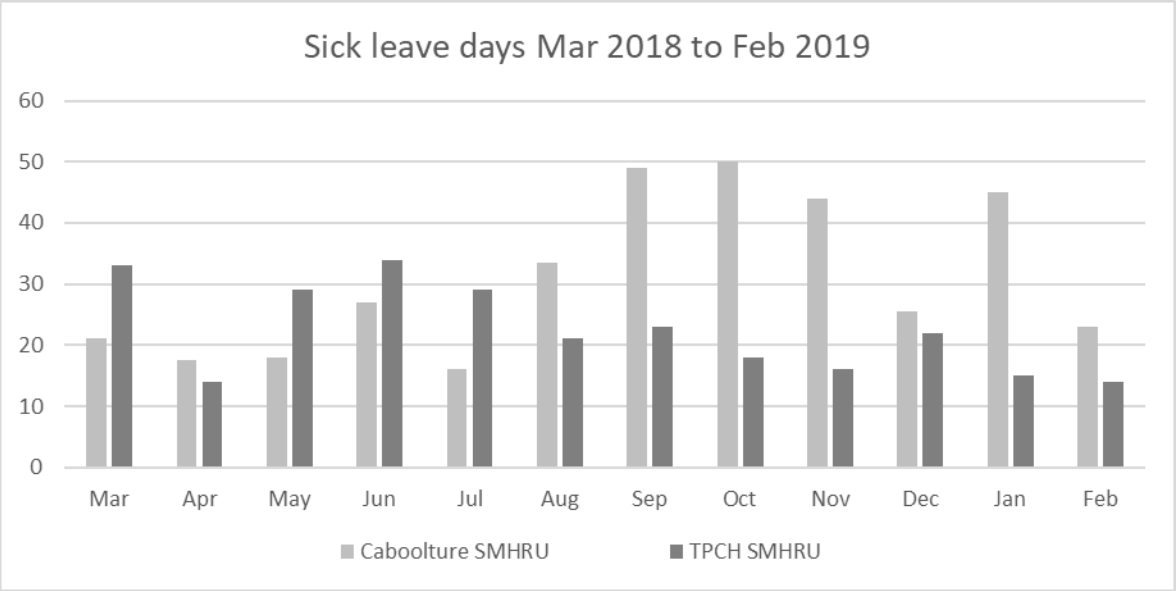



**Figure 7: Sick leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs each month from March 2021 to February 2022**

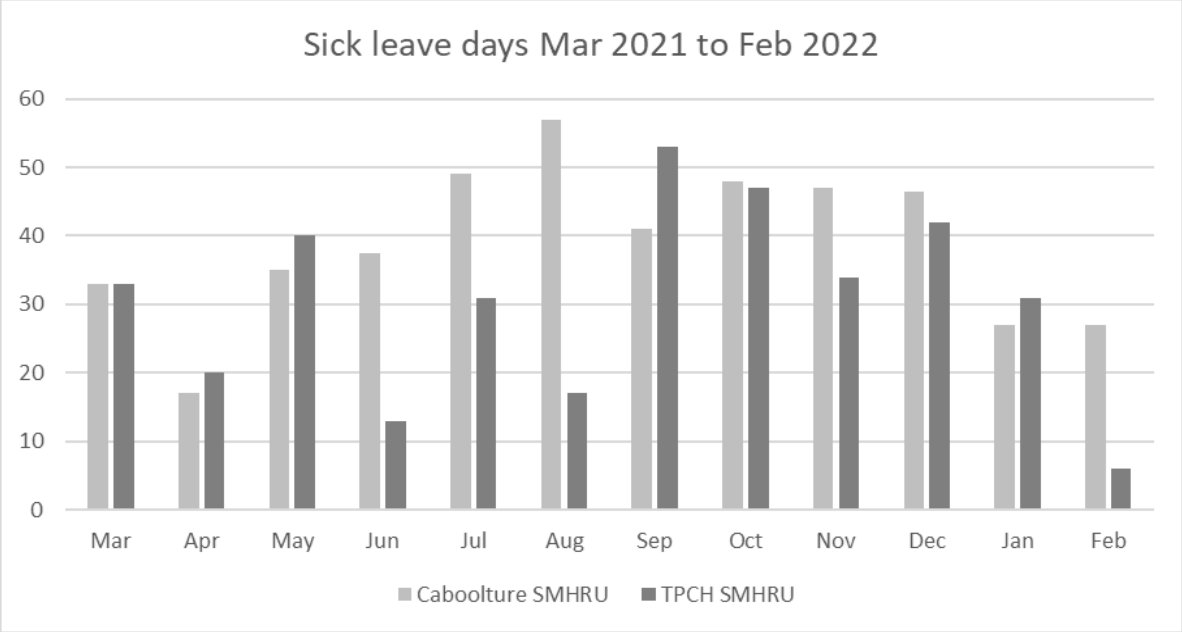
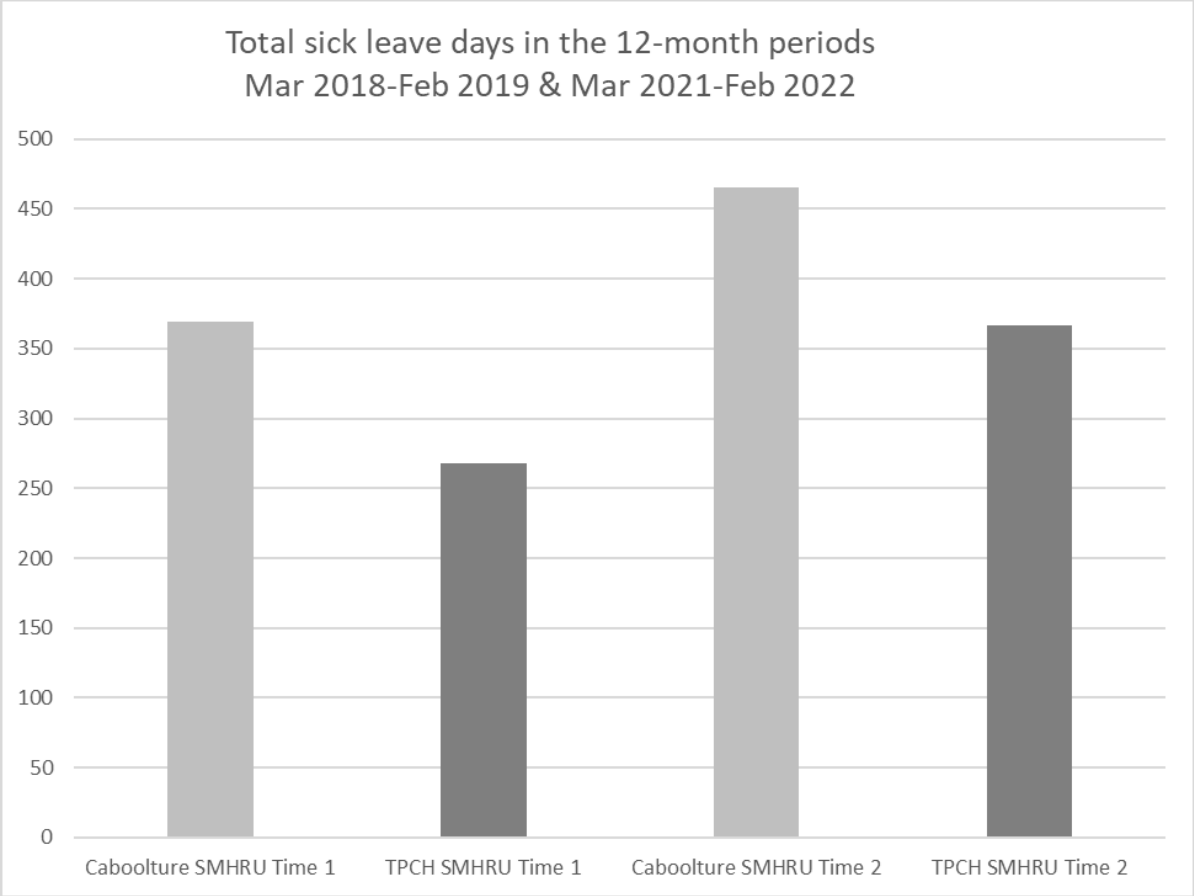


**Figure 8: Total numbers of sick leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs during two 12-month periods: March 2018 to February 2019, and March 2021 to February 2022**




While it is clear from the three charts above that TPCH SMHRU staff used less sick leave than Caboolture SMHRU staff during the two periods, it is also clear that this difference between the two groups existed prior to the implementation of RP in TPCH SMHRU. It therefore cannot be interpreted as a positive effect of using RP. It is also evident that the total number of sick leave days taken by staff in TPCH SMHRU was a great deal higher in Time 2, when the RP project was well underway, than in Time 1, prior to the implementation of RP. However, a similarly large increase in sick leave days occurred in the Caboolture SMHRU and both increases seem most likely to have been caused by the COVID-19 pandemic.

The number of WorkCover leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs during each month of the two 12-month comparison periods is shown in Table 19. The most striking features of this table are the drastic increase in WorkCover leave days taken in the Caboolture SMHRU during Time 2 (296 days), compared with Time 1 (1 day), and the considerable reduction in WorkCover leave days taken in TPCH SMHRU in the Time 2 (0 days) compared with Time 1 (53 days). However, it would be unwise to attribute the improved figures in TPCH SMHRU to the RP project, given that the usual number of WorkCover leave days taken each month during the earlier period was zero.

**Table 19: WorkCover leave days taken by nursing and allied health staff in Caboolture and TPCH SMHRUs each month during two 12-month periods: March 2018 to February 2019 (Time 1), and March 2021 to February 2022 (Time 2)**

| SMHRU | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Caboolture Time 1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| **TPCH Time 1** | 20 | 20 | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **53** |
| **Caboolture Time 2** | 51 | 19 | 8 | 9 | 9 | 34 | 38 | 16 | 19 | 32 | 37 | 24 | **296** |
| **TPCH Time 2** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |

### Online staff surveys

All three online staff surveys about RP use asked participants for their assessments of how useful RP had been in responding to situations where someone had caused or threatened to cause physical harm to someone else. Table 20 shows the responses of those who reported having experience of using RP and/or observing RP being used in such situations.

**Table 20: Staff perceptions of the usefulness of RP in situations where someone has caused or threatened to cause physical harm to someone else**

| Perceived usefulness | Work area | Survey 1 Jul-Aug 2020 | Survey 2 Jan-Feb 2021 | Survey 3 Aug 2021 |
|---|---|---|---|---|
| **Very useful** | SMHRU | 2 | 3 | 3 |
| | Nundah CMH | N/A | 0 | 4 |
| | Chermside CMH | N/A | 0 | N/A |
| | **Total** | **2** | **3** | **7** |
| **Moderately useful** | SMHRU | 3 | 5 | 2 |
| | Nundah CMH | N/A | 4 | 2 |
| | Chermside CMH | N/A | 0 | N/A |
| | **Total** | **3** | **9** | **4** |
| **Somewhat useful** | SMHRU | 5 | 4 | 5 |
| | Nundah CMH | N/A | 2 | 2 |
| | Chermside CMH | N/A | 1 | N/A |
| | **Total** | **5** | **7** | **7** |
| **Not at all useful** | SMHRU | 0 | 2 | 2 |
| | Nundah CMH | N/A | 0 | 0 |
| | Chermside CMH | N/A | 0 | N/A |
| | **Total** | **0** | **2** | **2** |

The majority of respondents to each survey who had used RP and/or observed it being used in situations where someone had caused or threatened to cause physical harm to someone else reported that it had been moderately or very useful. Most of the remaining respondents had found it somewhat useful. However, two respondents to Survey 2 and two to Survey 3 (who may have been the same two staff members) reported that RP had not been at all useful in such situations.

Surveys 2 and 3 included an additional question about how useful RP had been in responding to situations where someone had caused or threatened to cause another type of harm (i.e., not physical harm) to someone else. The responses of those staff who reported having used RP and/or having observed it being used in such situations are shown in Table 21. Here it can be seen that in both surveys, at least half of respondents to this question believed that RP had been either very useful or moderately useful in such situations. Most of the remainder reported that RP had been somewhat useful in such situations. Again, however, small numbers of SMHRU staff had found it not at all useful.

**Table 21: Staff perceptions of the usefulness of RP in situations where someone has caused or threatened to cause another (i.e., non-physical) type of harm to someone else**

| Perceived usefulness | Work area | Survey 2 Jan-Feb 2021 | Survey 3 Aug 2021 |
|---|---|---|---|
| **Very useful** | SMHRU | 1 | 1 |
| | Nundah CMH | 0 | 3 |
| | Chermside CMH | 0 | N/A |
| | **Total** | **1** | **4** |
| **Moderately useful** | SMHRU | 5 | 4 |
| | Nundah CMH | 5 | 3 |
| | Chermside CMH | 0 | N/A |
| | **Total** | **10** | **7** |
| **Somewhat useful** | SMHRU | 4 | 3 |
| | Nundah CMH | 3 | 2 |
| | Chermside CMH | 2 | N/A |
| | **Total** | **9** | **5** |
| **Not at all useful** | SMHRU | 2 | 3 |
| | Nundah CMH | 0 | 0 |
| | Chermside CMH | 0 | N/A |
| | **Total** | **2** | **3** |

The online surveys also asked staff how positive they felt, overall, about the introduction of RP into their work areas. As shown in Table 22, on each occasion a clear majority of respondents felt that RP had either already benefited their work area or would do so over time. By the time of Survey 3, when the project had been underway in the SMHRU for about 20 months, 10 of the 14 SMHRU

respondents felt positively about the project. However 2 were unsure about the project's value, while another 2 judged it to be a waste of time and effort. At the same time, all 13 respondents from Nundah CMH, where the project had been underway for about 14 months, felt positively about the project and 7 of them believed that it had already benefited their work area.

Analysis of their responses to other questions in the surveys suggests that those respondents who judged the RP project to be a waste of time and effort had reasons for doing so that were not necessarily related to their experience or observations of RP in use in their work areas. For example, the Chermside CMH respondent to Survey 2 who thought the RP project was a waste of time and effort had not done any RP training, had not used RP themselves and had not observed it being used by others in their work area. Similarly, neither of the two SMHRU respondents to Survey 3 who made this judgement had used RP themselves, and while one of them had observed it being used 'once or twice' in the SMHRU, the other had not observed it being used at all. The latter — who had not done any RP training — offered the following comment at the end of the survey:

> *We were using this practice twenty years ago… it has just been "rebadged" and called restorative practice… practicality and effectiveness … waste of time*.

**Table 22: Staff attitudes to the implementation of RP in their work areas**

| Response options | Work area | Survey 1 Jul-Aug 2020 | Survey 2 Jan-Feb 2021 | Survey 3 Aug 2021 |
|---|---|---|---|---|
| **I feel the RP project has already made a positive difference in my work area.** | SMHRU | 4 | 5 | 4 |
| | Nundah CMH | N/A | 4 | 7 |
| | Chermside CMH | N/A | 0 | N/A |
| | **Total** | **4** | **9** | **11** |
| **I feel the RP project will make a positive difference to my work area over time.** | SMHRU | 8 | 6 | 6 |
| | Nundah CMH | N/A | 7 | 6 |
| | Chermside CMH | N/A | 2 | N/A |
| | **Total** | **8** | **15** | **12** |
| **I'm not sure whether the RP project will make much difference to my work area.** | SMHRU | 1 | 2 | 2 |
| | Nundah CMH | N/A | 3 | 0 |
| | Chermside CMH | N/A | 5 | N/A |
| | **Total** | **1** | **10** | **2** |
| **I think the RP project is a waste of time and effort** | SMHRU | 0 | 1 | 2 |
| | Nundah CMH | N/A | 0 | 0 |
| | Chermside CMH | N/A | 1 | N/A |
| | **Total** | **0** | **2** | **2** |

Other survey respondents who offered comments about the benefits of using RP in their work areas were generally more positive. For example, one respondent to Survey 1 stated that *RP is definitely useful in SMHRU*, while another commented that:

> *Staff are able to reflect on their own practice using the Social Discipline Window. The use of affective statements & questioning appears to de-escalate potential situations.*

Several Survey 2 respondents offered similarly positive comments, such as these examples:

> *RP has been really valuable thus far, both with consumers but also in the team. I believe it has helped to strengthen connections between staff* (CMH team member).

> *My experience of using RP so far in my work area has been very positive* (SMHRU staff member).

Another, a CMH team member, was positive about RP, but doubted whether its potential benefits would be realised: *given huge time and resource limitations in the public system,* [RP] *will not be utilised to its full advantage.*

Two other respondents to Survey 2, both from the SMHRU, tended to contradict themselves when commenting about the benefits of using RP. Both began with somewhat dismissive remarks but then acknowledged aspects of RP that were or have the potential to be useful.

> [RP] *does not fit the patients in SMHRU but elements of the training are working well clients use the circles for morning meetings which is positive.*

> *Restorative practice is of limited benefit. Strategies to deal with conflict and conflict resolution are useful and so RP is useful in formalising this process but these are skills developed by practitioners anyway into their daily routine. I feel the course and practice more useful for beginning mental health practitioners. The foralised* [sic] *strategies*[7] *including the fishbowl are more relevant for more serious critical incidents and may be useful in the future.*

Survey 3 respondents offered a similar mix of comments on the benefits of RP, as the following examples show.

> *Its a great framework and very effective in SMHRU. Would like to see it implemented more widely.*

> *I find it a valuable teaching tool for new Grads and staff from non SMHRU areas to work in the green zone "with" the patient and avoid negative avoidable situations. Also directing staff to use RP when responding to challenging behaviours (both staff to staff and staff to patient) in a less confrontational and punishment orientated manner, having constructive interactions to avoid repetitive negative interactions.*

> *Affective statements are great tool to have* (CMH team member).

> *I still believe the very admission criteria for SMHRU patients tends to diminish the potential use.*

[7] By 'formalised strategies', this participant appears to have meant structured practices.

**Post-meeting questionnaires**

Analysis of the post-meeting questionnaires submitted by the 14 restorative meeting participants who did not identify as either a person who was harmed or a person who caused harm revealed that almost all of them found the meeting they attended personally beneficial. All but one expressed either agreement (8), strong agreement (4) or something in between these two options (1) with the statement, *The meeting was valuable for me personally*; the other gave a neutral response.

As mentioned previously, two versions of the questionnaire were used, which meant that two participants were not asked to respond to the following statements:

> *The meeting helped all participants to better understand the circumstances that led to the incident.*
>
> *The meeting helped all participants to better understand the impacts of the incident.*

However, the remaining 12 respondents all expressed either agreement or strong agreement with both of the above statements.

Some respondents to the post-meeting questionnaires offered additional comments about the meeting experience, and these were unanimously positive, as the following examples illustrate.

> *This was a wonderful meeting that enabled much greater understanding and sharing information that was new to some but should have been known. Much thought was shared on long-term and organizational improvements.*
>
> *Was an informative process and helped me personally understand the situation and effects on person involved.*
>
> *Helped me understand the impact on other as working in the environment where I been exposed to high levels of aggression, I may have become blunted to the impacts of aggression on others.*

**One-to-one stakeholder interviews**

The one-to-one interviews with SMHRU staff, in-reach staff and SMHRU consumers proved to be rich sources of data on the benefits of RP for the consumers, the staff themselves and the SMHRU community as a whole.

For example, almost all interview participants — including most of the consumer participants — commented enthusiastically on the benefits for consumers of using circles as a regular part of the morning meetings in the SMHRU. As one participant put it, the main purpose of the circles is *general relationship development and harm repair* (P1), and most others felt they were achieving this objective.

> *The circles* [are] *a huge improvement down there*. … *So just engagement in getting people to talk more. I think that's been really positive*. (P3)
>
> *It has been quite surprising that some patients who don't engage a lot actually are engaged in the circles and contribute to those circles. I think the patients get a lot from it.* (P5)

> *They're actually listening to each other's stories and responding to that. Not just with, 'Oh, this is how I think I should respond.' Actually responding. Because they've listened; they've heard what's happening. Even their verbal responses have been different or they've asked more questions and said, 'Oh, hey, are you okay, mate?'* (P28)

> *I think it does* [help]*, definitely, absolutely. I know it does, I've seen it firsthand. They get excited when it's their turn to talk. Sometimes people have their off days and they'll go 'Pass'. Usually we have an item that we hold* [a 'talking stick']*; we can't do that during COVID. Yeah, the circles are effective, I like it.* (P27)

Evidently the circles were beneficial for SMHRU staff and in-reach staff as well as for consumers. Some in-reach staff welcomed the more friendly relationships they had developed with consumers as a result of participating in the circles with them, as the following examples illustrate.

> *The circle. I really value that. I think actually, I like being — I mean, I always go anyway* [to the morning meetings] *but I find them more rewarding now. It's more meaningful and people are talking to me — the guys in there, they've always spoken to me, a lot more are talking to me about different things now … because they've got to know me a bit better or, you know… So, I think it's rewarding, to do the circles, yeah*. (P3)

> *It makes the staff more approachable in a way, like to show them that we care, and we want to know you're feeling, and it just — you know there's that open conversation. I think that's a really good healthy thing to have, especially in a place like this, where they're locked in, they don't have anyone to talk to apart from the others and the staff. So I think the relationships are quite important.* (P34)

Other staff members commented on the value of the information they obtained from circle discussions, which sometimes helps them in their day-to-day work on the ward.

> *You can also identify the things that are making them angry or pissing them off. You can identify them and then go back and try and solve that or at least even later bring that up with that person in a restorative way. Work out what we can do not to escalate it further there as well.* (P16)

> *I've found them to be generally really positive and a really useful way of both giving clients an opportunity to raise topics that they want to talk about but also using it the other way as an opportunity for us as staff to raise topics that we want to talk about with the clients as well, so I think that's actually been really useful.* (P1)

Several SMHRU staff members commented on how useful the circles had been during the COVID-19 pandemic, both for gaining insights into consumers' thoughts and attitudes and for helping them to understand the issues. This was particularly important in relation to the lockdowns, which — among other things — meant that consumers who would otherwise have been allowed leave were confined to the SMHRU.

> *It was actually very clear when we started talking about COVID in the circles that the clients actually had a really bad understanding of what was happening early on in the pandemic. They were misinterpreting a lot of the information they were seeing on the news and they didn't*

*really understand. So we were actually able to use the circles to support them to develop a better understanding, which was repairing the relationships because they started to understand that all these restrictions were actually around safety and a lot of them I noticed actually changed tack then and were kind of appreciative of being kept safe.* (P1)

*We did one about how lockdown is affecting the clients here, and that was really good to kind of get insight to how they were feeling and what they would like to do, and just get their opinion on it.* (P34)

*Like the cooking group when we were in lockdown. They voiced that and that's what we did, we made it happen. I think that kept us — it was a horrible time to be locked in with about 20 people locked together, and we had very little, if any, real violence in that.* (P16)

However, while they were supportive of the circles, a few interview participants — including one of the consumers, quoted below — pointed out that to be of value, the circles need to have meaningful topics, and this was not always the case.

*It can be useful if you talk about the right sort of things and do the right sort of things, it can be useful. It's — you know when it works properly — the best, because you get — it goes on longer than normal because people start talking. Start a conversation about something someone said. Someone else will start talking and another person will start talking. That's how you know when it works properly.* (P30)

Many SMHRU staff also reported finding RP useful as a framework to guide their everyday interactions with consumers, and ensure that they maintain objectivity, particularly when dealing with conflict between them.

*RP gives you a chance to stand back before you go in and think, 'Am I doing this the right way?' Or if you're feeling like your response is more punitive, is there some way that you can change your approach?* (P31)

*I think the questions are actually really useful in keeping that objectivity and not getting too skewed either way. So that's been really good.* (P1)

*I think it's a more positive framework definitely. You're not going to get as — you don't get the defensive reaction. Sometimes they can be really sensitive to things that you might think are fairly innocuous. Like they can — especially if there's a bit of a paranoid flavour to some of them, which they do have. I think that's been helpful as well. That's on a day-to-day basis.* (P4)

That this approach to incidents had a variety of benefits for consumers as well as staff was confirmed by many of the interview participants, including the medical staff and one of the consumers.

*The people who have been asked about what's happened to them and why they feel — and above all, what is it going to take to make it right, I think that kind of acknowledgement, that has some value because it gives you this idea that okay, I do matter around here. I think that's always something you want to hear.* (P29)

*I think it adds an enormous amount to maintaining good relationships. Understanding what's happened, being able to move forward in a positive way. Whereas the thing with incidents,*

*things that I was involved in historically … it was very confrontational and there was no positive path to follow, really, in resolving that.* (P20)

*It has been helpful, because it's made me realise there's a better way than doing it for someone or picking on someone or something. Do something with them. There is a better way.* (P30)

*I don't think a lot of* [the consumers] *have had an opportunity to explore why they're responding the way they are and I think this has allowed them to have a bit of space to do that and really reflect on their own responses to things as well. 'If someone does this and I respond in this way, how is that impacting them?' And 'Why is their behaviour impacting me to the point where I'm responding this way?' I've noticed that they're asking those questions a lot more. Even the staff. You know, 'Did I need to go off at a consumer for behaving that way or could I have had a gentle conversation and said, Hey, are you okay?'* (P28)

*I'm pretty confident that a lot of the handovers we're getting … the RP has made a difference. … We sort of arrive and are told about something that's happened on the weekend and the staff have already managed it and are using an RP approach and therefore the acuteness of it is no longer there. As opposed to if they hadn't done that there'd probably be somebody escalating still, out of feeling invalidated, so we'd probably be walking into an ongoing, bubbling, acute situation.* (P31)

Several interview participants acknowledged, however, that the restorative questions were not effective with all consumers — or not effective immediately.

*It does have limitations with its use, because of the nature of the clients we've got in here. We've got some people that are psychotic. We've got some people that do lack the ability or reason to see outside their own needs. … With some of these guys, it's a struggle to get there, but… it's a very good means of planting a seed. Oftentimes, because of the nature of where we work, it's the rehabilitation process here is a long process, so you'll often plant a seed. But it may not germinate when you want it to. If you plant the idea, but the wheels turn very slowly, and sometimes the seed will germinate later.* (P12)

*Some of the people you can — it will just go completely over their heads. They won't even — you can't even get through. But then there's other people that you can use it with which just calms them down. But it can also calm you down too. It works both ways definitely.* (P33)

Some of the interview participants commented on the usefulness of the RP framework, including the 'Social Discipline Window' (Appendix 3), as a teaching tool for new staff.

*I find the structure of it, that you can just show to a newbie or a grad, is brilliant. Because it's just, 'This is what we do; here's the tools to do it with'. It's not rocket science.* (P16)

*It's definitely of benefit for the newer staff when they come in and they're told about it, they need to use it, they begin to really feel it's of benefit for them*. (P36)

Many of the interview participants talked about how the introduction of RP into the SMHRU had benefited them personally. They included some who had taken part in restorative meetings, as

discussed earlier in this report, but also others who believed that RP had changed the way they do things for the better.

> *I used to be very — quite restrictive. I used to do, in the RP my type of nursing was a lot of to, rather than for, or — certainly not with. So it's enabled me to move out of that and allowed me to go into — moving to the 'with' box. So I've found that for me personally, it's helped me*. … *Walking with* [consumers on the road to recovery] *is so much easier than being the* [person] *who pushes them*. (P36)

> *I feel like that's been a really useful tool … that I've been able to use consistently, kind of delivering the same intervention, if you want to use that word, consistently. I think that's really good. It means for me as a clinician I'm more able to kind of keep track of what kind of support and intervention I'm providing to clients and measure that more consistently. … I think it definitely helps me build my rapport with clients and have a good therapeutic relationship with them. … I've definitely had a lot more clients seek me out.* (P1)

> *Has* [RP] *made a difference to me personally? Yeah, sort of, that acceptance that you've actually got to look at the fact that maybe something didn't go quite according to plan on my watch. What happened was on my watch so if something doesn't go well it makes you reflect on the fact, well, does this guy actually have something to complain about or to feel confronted about? So I think that made a difference.* (P29)

Several of the SMHRU staff and in-reach staff who participated in the interviews emphasised the compatibility of RP with the relatively recent rehabilitative role of the SMHRU.

> *I have noticed an increase in the hope that we can keep moving forward with this, particularly when we're looking at this is a mental health rehabilitation unit. We're looking at rehabilitating individuals to a point where they can be in community safely. If we are going to persistently look at things from a really punitive point of view, how is that reflective of the main goal of this environment?* (P28)

> *It gives them a sense of worth; they think they're being listened to and they're not spending as long in some sort of custodial/punitive agreement that we've made because they've done something wrong. We can identify what happened, stop it before it gets to that end stage and hopefully everyone keeps rehabbing*. (P16)

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 prior to RP being implemented were able to identify changes they had observed. Significantly, none of them mentioned any negative impacts. Instead, among other changes, they talked about improvements to the culture, better therapeutic relationships, and a decline in violence.

> *I think it has broken down the us and them, nurse and patient barrier to an extent*. (P20)

> *It's not as violent to start with. It's more settled when* [staff] *walk onto the floor so they don't always feel like you're walking with your back up all the time.* (P16)

> *You'd have to look at historical data but I think there's been less assaults and less — the annexe area's definitely been locked a lot less than it has been before. A lot less. There's been a few — recently, there's been some new patients that have had a few assaults, but as a whole if you take it patient per patient, I think it will be down. There's a few per cent that have been violent. But I think as a whole, we would be down and as I said, that annexe area until very recently was unlocked for a long period. I don't think in the last two years I've ever known it to be open as often as it has been.* (P16)

> *I think some of the culture has shifted*. (P28)

> *The biggest difference that it's made that I've observed is that there seems to be, to me, a more collective understanding amongst the clients that there is interest from the staff group around what is going on and how we can make things better and that we want to work with them. I think that's a really important dynamic here. We have a larger group of clients who understand that we want to work with them. I feel like we do a lot better with the client group as a whole.* (P1)

> *I think just more therapeutic relationships. Open conversations.* (P34)

> *I think it's slowly shifting some of the really ingrained ideas around support or lack of support from the* [staff] *down here. And also from the consumers themselves, helping shift where they identify themselves a lot of the time in a really negative or self-deprecating space, where they don't feel that they're worth enough of anything more than violence and abuse, seeing that shift in them … I think that's really, really warming to see.* (P28)

However, not all interview participants were certain that RP had been the sole cause of some of the changes. For example, while agreeing that the culture of the ward had changed, one SMHRU staff member said, *That could be because of RP. It could be because of staff changes*. They noted that there were still a few staff who were very punitive in their approach, *But on the whole, I think it's moved. I think RP may be a part of that* (P5).

Similarly, one of the consumers was positive that RP was *a good thing*, but was unsure whether the changes he had observed over the last two years were attributable to the RP project.

> *I don't know. It seems different than what it was like when I first got here. Some of the rules in, some ways, are tighter, some of the rules are more relaxed. But — I don't know. I don't know if it's because of Restorative Practice or if that's just a change over time anyway. Sometimes it can be better. Yeah, I suppose I'd say, yes, sometimes it's better. Depending on the nurses you get in the situation.* (P30)

Finally, interview participants were asked whether they thought there had been any negative consequences of implementing RP in the SMHRU. They were almost unanimous in responding that there had been no downside to introducing RP. The few exceptions were people who referred to the potential for RP to be utilised inappropriately or to challenges to the sustainability of the RP project, discussed earlier in this report.

> *I think if there are any negative consequences, that's because you're trying to use it for something that it's not designed to do*. (P12)

*The only negative aspect I suppose is not all the staff getting on board and I think that's really difficult if you're trying to make a cultural change*. (P34)

*The only negative thing is it could be so much better if we had maybe an outside party that could come down and reinforce it with our patients and with our staff because we know that when* [the RP Lead] *leaves, that's it.* (P36)

# Discussion

The project to implement RP in mental health services at TPCH was challenging, not least because RP has not previously been implemented in any Australian mental health services. There is scant research evidence on the efficacy of RP in mental health services elsewhere, and the small amount of literature available focuses on examples of restorative meetings following incidents of significant harm, rather than on the use of proactive restorative practices to improve relationships and prevent conflict. Moreover, the available literature offers little in the way of guidance on how best to implement RP in secure mental health facilities and nothing to inform its implementation in community-based mental health services. Planning for the RP project, including the development of an appropriate RP model for TPCH mental health services, was therefore heavily dependent on the findings of Power (2017) during his Churchill Fellowship project and on subsequent discussions with the network of overseas colleagues he developed as a result of that project.

In this context it is not surprising that the project team was initially focused more on the reactive than the proactive aspects of RP, and that, in turn, mental health staff found it difficult at first to recognise how the implementation of RP in their workplaces might be relevant or beneficial for either their patients or themselves. Similarly, it is understandable that, beyond sponsoring the project and chairing the project Steering Committee, the executive leadership team within TPCH Mental Health were not actively involved in the implementation of RP. The competing demands on their time no doubt limited their ability to participate in any of the three-day skills workshops. Moreover, with RP introduced into only three of TPCH's many mental health services, and no clear plans for rolling it out further, it seems likely that more active involvement in the project was not a high priority for the executive leadership team, particularly during a pandemic. It may also be the case that — without the understanding that they would have acquired through participation in the workshops — they struggled to identify ways in which they could be more actively involved. In this sense, the executive leadership team perhaps failed to perceive the relevance of RP to their work, just as so many staff in the SMHRU and the two CMH teams — particularly the Chermside CMH team — could not, at least initially, see its relevance to theirs.

Considering the multiple challenges identified in this evaluation, the implementation of RP in both TPCH SMHRU and the Nundah CMH team must be regarded as a significant achievement, even given most stakeholders' expressed doubts about its sustainability without further support. This evaluation has identified some potential improvements that may strengthen the sustainability of RP in those two service areas. Most of them — such as those that involve the development of training and other resources — would clearly require substantial additional funding. However, others could be implemented with minimal resources yet yield multiple benefits.

It seems clear, for example, that the executive team's more active involvement in the RP project would send a powerful message to staff in the SMHRU and the Nundah CMH team, while also supporting the process of culture change necessary to ensure the sustainability of RP in those service areas. Certainly it would be vital for the successful introduction of RP into other units within TPCH Mental Health.

The findings presented above also offer some other 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 or project coordinator within the teams where RP is being implemented, as advocated by Drennan and Swanepoel (2021). This might only be for one or two days per week, but persevering with this arrangement for at least several months, preferably longer, is clearly necessary to sustain implementation over the long term. However, co-location needs to be managed carefully, and to be actively supported by team leaders. This means, among other things, recognising and treating the RP Lead as a member of the team whenever they are present. It should be taken for granted, for example, that the RP Lead participates in team meetings.

The active support of team leaders could be fostered by not only enabling them to participate in the RP training ahead of their teams — as was done in this case — 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 to coach them through a 'soft' implementation of regular team activities such as circles and fishbowls, prior to the rest of the team being trained.

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 — as Hew (2020) has implied — 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. Such an approach might have minimised the likelihood of staff perceiving a formal restorative meeting to be the desired end point of all restorative practices — and perhaps prevented the Chermside CMH team's withdrawal from the project.

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 for parties, 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.

The fact that so few facilitated restorative meetings were held during the study period means that the evidence of benefits both for people who have been caused harm and for the TPCH mental health service consumers or staff who caused that harm, while unequivocal, is not strong enough to allow any firm conclusions to be drawn. Further research is needed. Nevertheless, this study adds weight to the existing body of research that indicates that restorative meetings are beneficial for all participants (e.g., Cook 2019, Cook et al 2015, Tapp et al 2020, Van Denderin et al 2020).

The evidence presented in this report on the range of benefits that RP has delivered for other stakeholders, particularly in TPCH SMHRU, is considerably stronger. While the two EssenCES surveys did not show an improvement in the social climate of the SMHRU, the extensive qualitative data gathered during the stakeholder interviews suggests that the SMHRU's social climate has indeed improved, to at least some extent, particularly in the domain of 'therapeutic hold'. This is important, given the rehabilitative purpose of the SMHRU, and is consistent with Cook's (2019) conclusion that RP can help maintain the therapeutic climate of a secure mental health ward.

Another apparent outcome of the RP project in the SMHRU was a statistically significant reduction in both the number of seclusion events and the rate of seclusion events per 1,000 bed days. Although seclusion events are sometimes voluntary and are not necessarily related to aggressive behaviour, this finding could point to a reduction in conflict and aggression, as perceived by some SMHRU staff members.

As in the study by Cook et al (2015), most staff in the SMHRU and the Nundah CMH team viewed the RP project favourably, and many believed they had benefited professionally and/or personally from using RP on a day-to-day basis. Indeed, it seems that most of the benefits to be gained from the implementation of RP in TPCH mental health services are likely to be the result of the everyday use by mental health staff of proactive high-volume, low-intensity RP skills and processes.

## Limitations of the study

Both components of this evaluation had some limitations that need to be acknowledged. For example, it seems likely that the online staff survey results and the stakeholder interview data — both of which contributed to both the process and the outcomes evaluation — were affected by some level of response bias. Staff with negative attitudes towards the RP project and those who had not done any RP training may have been less inclined than others to complete the surveys or to participate in the interviews — despite strong encouragement to do so. That said, the small number of respondents to Surveys 2 and 3 who expressed the view that the RP project was a waste of time and effort may well have comprised the majority of those with such opinions. According to participants in the second round of interviews, only two or three SMHRU staff still held strongly negative views towards the RP project by mid-2021.

To some extent, the design of the outcomes component of the evaluation suffered from the same problem that led to some early challenges for the RP project itself — namely, an overly strong focus on the potential benefits to be gained from facilitated restorative meetings. Planning for the evaluation took place before implementation commenced, as is usually considered good practice. However, in this case, the expectation that there would be considerably more restorative meetings than there actually were during the study period led to the development of evaluation questions and data collection methods that, in hindsight, were not as well matched to each other as they might have been. For example, while the third round of stakeholder interviews yielded a large amount of rich data on the wide range of benefits the implementation of RP in TPCH SMHRU had achieved for staff, consumers and the SMHRU community as a whole, a structured survey might have been a better way of assessing the extent of those benefits. On the other hand, the response rates in the SMHRU to both the online surveys and the EssenCES questionnaire suggest that yet another survey might not have been well received.

The limitations of the Riskman data obtained from Metro North Mental Health meant that it was not possible to draw any firm conclusion on whether the implementation of RP led to an overall reduction in incidents of consumers causing or threatening harm to others, although — as shown in the RP project logic model (Figure 1) — this was identified as a potential outcome of the project.

Finally, the sick leave data for the 12-month period 1 March 2021 to 28 February 2022, which might otherwise have served as an indicator of another potential outcome of the RP project — improved staff morale in TPCH SMHRU — was clearly affected by the COVID-19 pandemic.

# Conclusions

While the number of facilitated restorative meetings that occurred during the study period was insufficient to support a quantitative outcomes study, this mixed methods evaluation goes some way towards strengthening the evidence base for RP in mental health settings. The evaluation gathered considerable evidence that the implementation 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.

Through the inclusion of a process study, the evaluation has also helped address a gap in the research on what constitutes good practice in implementing RP in mental health settings. It identified aspects of the RP project that worked well and some potential improvements that could assist the sustainability of RP in TPCH mental health services. Moreover, it offers some learnings that could be considered in any future implementations of RP in mental health settings, whether they are secure inpatient facilities or community-based services.

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# Appendices

# Restorative Practice in the Community Mental Health Service Teams at The Prince Charles Hospital (TPCH) and the SMHRU

RESTORE REPAIR RELATIONSHIPS

## Restorative practice principles

- Restoration –those most impacted involved
- Voluntary
- Non-judgemental – supportive to all participants
- Safety – do no further harm
- Accessible – Empowerment and participation
- Do with (not **'for'** or **'to'**)
- Respect

## Social discipline window – the restorative framework


Adapted from Paul McCold and Ted Wachtel

## Restorative practice continuum

**AFFECTIVE STATEMENTS**

- Brief 'I' statements about how others affected by behaviour
- Inserting feeling and impact of behaviour into statement
  e.g. "I'm worried when you use that language that it is hurtful for others"
  See poster for more details.

**AFFECTIVE QUESTIONS**

- One step further - asking **'who'** was affected and **'how'**
- Using the Restorative Questions card with the person who caused harm (Qs1 on card), and separately with the person harmed if possible (Qs 2 on card)

**IMPROMPTU RESTORATIVE MEETING**

- If safe, and consented to by both parties separately using the Restorative Questions, bringing the people most impacted by an incident to meet/ communicate to help resolve the issue

**RESTORATIVE CIRCLE**

- Group discussion allowing all participants to have a say, Check in/Check out circles can be used to support relationship building, goal setting, or to address a particular issue for example

Informal/no or minimal preparation required — RESTORATIVE PRACTICE CONTINUUM — More formal/more preparation required

## RESTORATIVE MEETING (using external facilitator)

- Bringing the person who caused harm and the person who has been harmed (or a proxy/rep if appropriate) together to promote relationship repair, support repair of harm, and promote healing
- Using Adult Restorative Justice Conferencing to facilitate
- Shuttle communication also possible if appropriate

Metro North Health | Queensland Government


**For more information you can contact: Restorative Practice Lead 0439 428 317 | restorative@health.qld.gov.au**


Social Discipline Window and Restorative Practice Continuum adapted from International Institute of Restorative Practice https://www.iirp.edu/restorative-practices/defining-restorative/

APPENDIX 1

**APPENDIX 2**

## Affective (restorative) questions

### Restorative Questions I

*When Things Go Wrong*

- What happened?
- What were you thinking of at the time?
- What have you thought about since?
- Who has been affected by what you have done? In what way?
- What do you think you need to do to make things right?

### Restorative Questions II

*When Someone Has Been Hurt*

- What did you think when you realised what had happened?
- What impact has this incident had on you and others?
- What has been the hardest thing for you?
- What do you think needs to happen to make things right?

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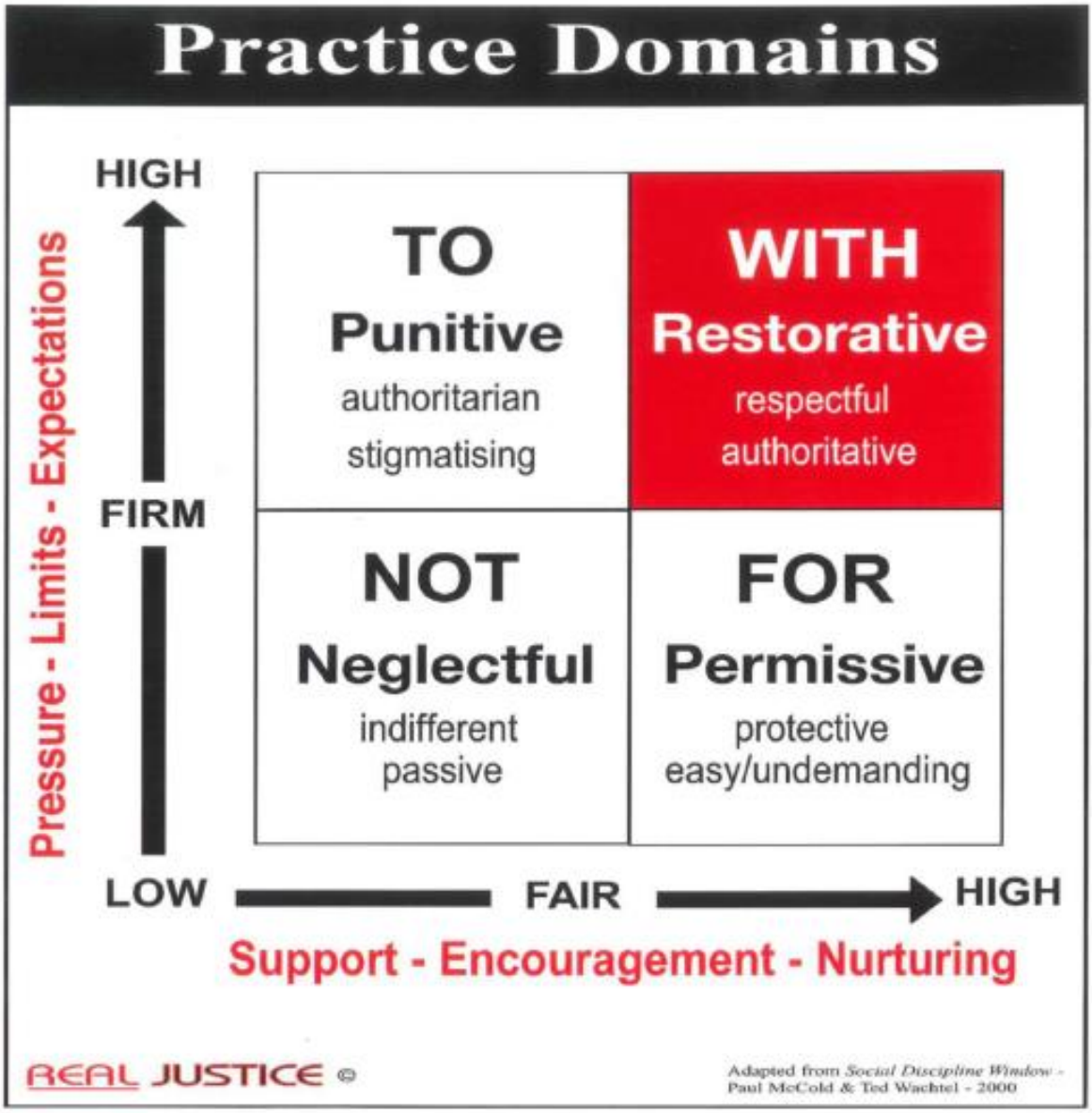
**APPENDIX 3**

**The social discipline window (practice framework)**



**APPENDIX 4**

# ‘COMPASS OF SHAME’ (draft version)

## Restorative Meetings in Community health Service Teams associated with TPCH

RESTORE REPAIR RELATIONSHIPS

Sometimes things happen that will impact on our emotions. It could be as a result of something we or others do or say.

- What do you think of when you hear the words *guilt* or *shame* – is there a difference?

Guilt is an emotion which suggests “I have done something bad” and motivates us to do something to make things better. Shame is a feeling that “I am bad” and causes us to fear rejection if something about us was known, even if shame was originally brought about by other people’s harmful actions against us (Brene Brown, 2014).
Shame can occur any time that our experience of a positive affect is interrupted, and shame can make us feel that we are “bad” (Tomkins, 1987).

We do not have to do something wrong to feel shame, we just have to experience something that interrupts interest-excitement or enjoyment-joy (Nathanson, 1997a).

Here are some of the possible reactions we all might have when we feel shame.
We sometimes try to keep those things hidden.


Restorative practices provide an opportunity for us to express our shame, along with other emotions, and in doing so reduce their intensity.

Adapted from [www.iirp.edu/defining-restorative/compass-of-shame](www.iirp.edu/defining-restorative/compass-of-shame)

**APPENDIX 5**

# WORKSHOP EVALUATION FORM

## Restorative Practice in mental health services

### Presenter: Kerrie Sellen, in association with QHVSS

Restorative Journeys

*Please complete the evaluation for the training delivered by Restorative Journeys for the Restorative Practice in mental health services project. Your experience is important, and all feedback is valuable.*

**Which day/s did you attend? (please tick)**

**Day 1** ☐ **Day 2** ☐ **Day 3** ☐

| Statement | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| The trainer was knowledgeable and effective. | | | | | |
| The trainer encouraged active participation and interaction. | | | | | |
| The training was relevant to my workplace needs. | | | | | |
| I developed new skills and strategies relevant to my work. | | | | | |
| I am confident I can use restorative dialogue in my work. | | | | | |
| I am confident I can facilitate restorative circles in my workplace. | | | | | |
| I am confident I can effectively support participants in restorative meetings in my workplace. | | | | | |
| I am confident I can share what I've learned about restorative practice with my workplace colleagues. | | | | | |
| I can see the potential for restorative practice to be valuable in my workplace. | | | | | |
| The training will make a difference to the way I do my job. | | | | | |
| The training met or exceeded my expectations. | | | | | |

| |
|---|
| What are the three most important things you learned from the training? |
| Was there anything you would have liked more or less of? |
| What would you say to others about the training? |
| What else is needed to support the use of Restorative Practice within TPCH SMHRU or CMH teams? |

My work area is (please tick)

- ☐ Chermside Community Mental Health Team
- ☐ Nundah Community Mental Health Team
- ☐ Secure Mental Health Rehabilitation Unit
- ☐ Other (please state): _____

**Thank you very much for your feedback.**

At times, Restorative Journeys like to use quotes from our workshop participants. Please indicate below if you are happy for us to quote you.

- ○ Yes, you can use my feedback, including my name.
- ○ Yes, you can use my feedback, but I prefer to remain anonymous.

**Signed:**_____ **Name:**_____

**APPENDIX 6**

# Participant information sheet
# Phase 1 Round 1 face-to-face interviews

**Project title**

Restorative Practice in mental health services project evaluation

**Purpose of study**

You are invited to participate in an independent evaluation of the Restorative Practice (RP) in mental health services project currently underway at The Prince Charles Hospital. The evaluation aims to assess the effectiveness of RP in mental health services while also identifying opportunities to improve the RP models and/or their implementation.

**Your participation**

You are being asked to participate in this evaluation because of your role in developing and/or implementing the RP project.

Specifically, you are invited to participate in one or more semi-structured face-to-face interviews with a member of the research team, to be conducted at your workplace. The interviews will explore your views on the progress of implementation so far, including how well you think you and other stakeholders were prepared for the RP project, the challenges experienced so far, things that you think have worked well, and how you think the project might work better. The interviewer will not ask you for any personal information; nor will you be asked to comment on the performance of any particular people involved in the RP project.

With your permission, we will send you a short set of questions by email a few days before your interview. Please note that you are not required to answer these questions in writing; they are intended to help you refresh your memory and clarify your thoughts in preparation for the interview. Some additional questions are likely to be asked at the interview itself.

Again with your permission, we will digitally record your interview and have the recording transcribed by a professional transcription service. If you do not wish your interview to be recorded, the interviewer will make handwritten notes instead.

You might be asked to participate in another interview at a later point in the evaluation project.

**Your rights**

It is important that you understand that your participation in the evaluation is voluntary.

If you decide not to participate, there will be no penalties or other negative consequences.

If you decide to participate in the evaluation, you also have the right to change your mind. You may discontinue your participation at any time before the evaluation is completed (approximately April 2022), and you may do so without providing any explanation. You may also request the research

team to withdraw and destroy any information you have already provided. All information you provide — including the digital recording, the transcription, and any handwritten notes taken by the interviewer — will be treated as confidential and will be kept securely by the research team. It will be used only for the purposes of the evaluation. Your name will be replaced by a unique code to protect your identity.

You have the right to ask questions about the evaluation procedures and to have them answered. If you have any questions, please ask them before the interview begins.

**Benefits**

While there are no direct benefits to participating in this evaluation, you may enjoy the opportunity to discuss and reflect on the challenges involved in the RP project, the aspects of it that have worked well and those that have not, and how the RP model or its implementation might be improved. More broadly, both mental health staff and mental health consumers will benefit in the longer term from improved knowledge and evidence about the benefits of RP in mental health services and how best to implement it in such contexts.

**Risks**

There are no specific risks associated with your participation in either this interview or the evaluation as a whole. However, if you have previously been harmed by a mental health consumer, it is possible, albeit unlikely, that you may find the interview upsetting, so you might like to have a support person attend the interview with you. Either way, if you find you are becoming uncomfortable you can discontinue the interview at any time without prejudice.

It is important that you understand that, in a small study such as this, we cannot guarantee to protect your identity. To the extent possible, in reporting the findings of the study we will avoid referring to individual people we have interviewed; if we need to mention individuals, we will do so by using a pseudonym and/or a generic position title. However, there remains a risk that you will still be identifiable to readers, particularly colleagues with knowledge of the RP project.

**Further information**

The evaluation of the RP project is being conducted by a team of independent consultants led by Dr Diana Beere, who would be glad to answer your questions about the evaluation at any time. You may contact her on 0439 837 783 or at dianabeere@gmail.com. You should also contact her if you want to learn about the findings from the evaluation.

The evaluation plan has been reviewed by The Prince Charles Hospital Human Research Ethics Committee and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018). If you would like to discuss your participation in this evaluation with someone who is not involved in it, you may contact the Research, Ethics and Governance Unit at The Prince Charles Hospital on 07 3139 4500 or at ResearchTPCH@health.qld.gov.au.

# Participant consent form
# Phase 1 Round 1 face-to-face interviews

**Project title**

Restorative Practice in mental health services project evaluation

**Statement**

- I have read the Participant Information Sheet for this project, and have been given a copy to keep.
- I have been given an opportunity to ask questions about the evaluation.
- I understand that my involvement is voluntary and that there is no penalty for not participating, or for changing my mind about participating.
- I understand that I may withdraw from participating in the evaluation at any time without explanation, and may ask the research team to destroy any information I have already provided.
- I agree to participate in the evaluation and for information provided by me to be stored and used as described in the Participant Information Sheet.

**Name:** _____

**Signature:** _____ **Today's date:** _____/_____/_____

**APPENDIX 7**

# Restorative Practice in mental health services project evaluation
# Phase 1 face-to-face interviews, Round 1

## Question guide

1. Please tell me your role and in what way you are involved in the Restorative Practice in mental health project (the RP project).
2. Thinking back over the last few months, and about the information and/or training you received before the RP project started, how well prepared do you think you were for the implementation of RP in The Prince Charles Hospital (TPCH) Secure Mental Health Rehabilitation Unit (SMHRU)?
3. In your opinion, how well prepared were others — including both staff and consumers?
4. What, if anything, do you think could have been done that would have enabled staff and consumers to be better prepared for the implementation of RP in the SMHRU?
5. One of the aims of the RP project is to establish the SMHRU as a 'restorative ward'. It's still quite early in the project, but how do you think that's going so far?
6. Are you aware of any problems or challenges that have been encountered during the RP project so far? If so, please tell me about them, and about how they've been overcome.
7. Are there any aspects of the RP project generally, or the RP model in particular, that you think have worked particularly well? If so, please tell me about them, and about why you think they've been effective.
8. Can you suggest any ways in which the RP model or the way RP has been implemented in the SMHRU could be improved?
9. Do you have any other comments to make about the RP project at this stage?

**APPENDIX 8**

# Restorative Practice in mental health services project evaluation
# Phase 1 Round 2 face-to-face interviews

## Question guide

1. Please tell me your role and in what way you are involved in the Restorative Practice in mental health project (the RP project).
2. [*For people not previously interviewed*] Thinking back over the life of the RP project so far, and about the information and/or training you received before the project started in your work area, how well prepared do you think you were for the implementation of RP in The Prince Charles Hospital (TPCH) mental health services?
3. [*For people not previously interviewed*] In your opinion, how well prepared were other people in your work area?
4. [*For people not previously interviewed*] What, if anything, do you think could have been done that would have enabled you and/or others to be better prepared for the implementation of RP in TPCH mental health services?
5. [*For SMHRU staff only*] One of the longer-term aims of the RP project is to establish the SMHRU as a 'restorative ward', which is something that involves culture change. The project has been running in the SMHRU for just over a year now, so I'm keen to hear your thoughts on how that culture change is going at this stage.
6. Are you aware of any problems or challenges that have been encountered during the RP project so far — including any barriers to implementation in your work area? If so, please tell me about them, and about whether and how they've been overcome.
7. Are there any aspects of the RP project generally, or the RP model in particular, that you think have worked particularly well? If so, please tell me about them, and about why you think they've been effective.
8. Can you suggest any ways in which the RP model or the way RP has been implemented in TPCH mental health services could be improved?
9. In your view, what would be necessary to ensure the sustainability of RP in TPCH mental health services over the long term?
10. Do you have any other comments to make about the RP project at this stage?

**APPENDIX 9**

UNIVERSITÄT DUISBURG ESSEN

# Essen CES©

Essen Climate Evaluation Scheme
- gender neutral 2020 -

LVR Qualität für Menschen

| | | I agree | | | | |
|---|---|---|---|---|---|---|
| | | not at all | little | somewhat | quite a lot | very much |
| 1 | This ward has a homely atmosphere | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | The patients care for each other | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | Really threatening situations can occur here | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | On this ward patients can openly talk to staff about all their problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5 | Even the weakest patient finds support from his/her fellow patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6 | There are some really aggressive patients on this ward | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7 | Staff take a personal interest in the progress of patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | Patients care about their fellow patients' problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | Some patients are afraid of other patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10 | Staff members take a lot of time to deal with patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | When patients have a genuine concern, they find support from their fellow patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | At times, members of staff are afraid of some of the patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | Often, staff seem not to care if patients succeed or fail in treatment | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | There is good peer support among patients | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | Some patients are so excitable that one deals very cautiously with them | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | Staff know patients and their personal histories very well | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17 | Both patients and staff are comfortable on this ward | ☐ | ☐ | ☐ | ☐ | ☐ |

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University Duisburg-Essen | P.O. Box 10 30 43 | 45030 Essen | Germany

**APPENDIX 10**

# Restorative Practice in mental health services project evaluation

## Post-meeting questionnaire (person harmed)

Thank you for agreeing to complete this questionnaire, which is part of an independent evaluation of the Restorative Practice in mental health services project currently underway at The Prince Charles Hospital.

You are being asked to complete this questionnaire because you have just participated in a facilitated restorative meeting with a person who has caused you harm. We are interested in finding out how well these meetings are working from the point of view of participants.

Please note that the questionnaire does not ask for your name and your answers will be kept confidential; no-one except the researchers will see them.

The questionnaire *should take you no more than 5 minutes to complete*.

Please respond to each statement by ticking the box beside it that best matches your level of agreement with that statement. Please be as honest as you can; we are keen to get your honest opinions, whether they are positive or negative.

To make sure no-one else sees your answers, *please put your completed questionnaire in the attached envelope, seal the envelope and return it to the meeting facilitator*, who will post it to the research team.

---

**PLEASE TURN TO THE OTHER SIDE OF THIS PAGE**

| Statement | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I felt well prepared for the meeting. | | | | | |
| The facilitator managed the meeting well. | | | | | |
| It was easy to understand what was going on. | | | | | |
| The meeting was fair on me. | | | | | |
| The meeting was fair on the person who harmed me. | | | | | |
| The meeting allowed me to explain the impact of the incident on me. | | | | | |
| The meeting allowed the person who harmed me to tell their story. | | | | | |
| I think the person who harmed me understood the impact of the incident on me. | | | | | |
| I now understand the circumstances that led that person to harm me. | | | | | |
| The person who harmed me took responsibility for what they did. | | | | | |
| The meeting gave all participants an opportunity to say how things can be improved and/or repaired. | | | | | |
| I am satisfied with the meeting outcomes. | | | | | |
| The meeting was valuable for me personally. | | | | | |
| I would recommend a restorative meeting to others who have been harmed by someone else. | | | | | |
| **Please share any additional comments you may have about the meeting.** | | | | | |
| **I agree to my feedback being shared with the meeting facilitator. YES / NO** | | | | | |

**THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.**
**Please seal it into the attached envelope and return it to the meeting facilitator.**

**APPENDIX 11**

# Restorative Practice in mental health services project evaluation

## Post-meeting questionnaire (person who caused harm)

Thank you for agreeing to complete this questionnaire, which is part of an independent evaluation of the Restorative Practice in mental health services project currently underway at The Prince Charles Hospital.

You are being asked to complete this questionnaire because you have just participated in a facilitated restorative meeting with a person to whom you caused harm. We are interested in finding out how well these meetings are working from the point of view of participants.

Please note that the questionnaire does not ask for your name and your answers will be kept confidential; no-one except the researchers will see them.

The questionnaire *should take you no more than 5 minutes to complete*.

Please respond to each statement by ticking the box beside it that best matches your level of agreement with that statement. Please be as honest as you can; we are keen to get your honest opinions, whether they are positive or negative.

To make sure no-one else sees your answers, *please put your completed questionnaire in the attached envelope, seal the envelope and return it to the meeting facilitator*, who will post it to the research team.

---

**PLEASE TURN TO THE OTHER SIDE OF THIS PAGE**

| Statement | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I felt well prepared for the meeting. | | | | | |
| The facilitator managed the meeting well. | | | | | |
| It was easy to understand what was going on. | | | | | |
| The meeting was fair on me. | | | | | |
| The meeting was fair on the person I harmed. | | | | | |
| The meeting allowed me to tell my story about the incident. | | | | | |
| The meeting allowed the person I harmed to explain the impact of the incident on them. | | | | | |
| I think the person I harmed understood why I harmed them. | | | | | |
| I now understand the impact of the incident on the person I harmed. | | | | | |
| I take responsibility for what I did. | | | | | |
| The meeting gave all participants an opportunity to say how things can be improved and/or repaired. | | | | | |
| I am satisfied with the meeting outcomes. | | | | | |
| The meeting was valuable for me personally. | | | | | |
| The meeting will help me to avoid repeating the behaviour that caused harm. | | | | | |
| I would recommend a restorative meeting to others who have caused harm to someone else. | | | | | |
| **Please share any additional comments you may have about the meeting.** | | | | | |
| **I agree to my feedback being shared with the meeting facilitator. YES / NO** | | | | | |

**THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.**
**Please seal it into the attached envelope and return it to the meeting facilitator.**

**APPENDIX 12**

# Restorative Practice in mental health services project evaluation

## Post-meeting questionnaire (support person)

Thank you for agreeing to complete this questionnaire, which is part of an independent evaluation of the Restorative Practice in mental health services project currently underway at The Prince Charles Hospital.

You are being asked to complete this questionnaire because you have just participated, as a support person, in a facilitated restorative meeting between a person who has been harmed and the person who caused the harm. We are interested in finding out how well these meetings are working from the point of view of participants.

Please note that the questionnaire does not ask for your name and your answers will be kept confidential; no-one except the researchers will see them.

The questionnaire *should take you no more than 5 minutes to complete*.

Please respond to each statement by ticking the box beside it that best matches your level of agreement with that statement. Please be as honest as you can; we are keen to get your honest opinions, whether they are positive or negative.

To make sure no-one else sees your answers, *please put your completed questionnaire in the attached envelope, seal the envelope and return it to the meeting facilitator*, who will post it to the research team.

---

**PLEASE TURN TO THE OTHER SIDE OF THIS PAGE**

| Statement | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I felt well prepared for the meeting. | | | | | |
| The person I supported felt well prepared for the meeting. | | | | | |
| The facilitator managed the meeting well. | | | | | |
| It was easy for the person I supported to understand what was going on. | | | | | |
| The meeting was fair on the person I supported. | | | | | |
| The meeting was fair on the other person. | | | | | |
| The meeting allowed the person I supported to tell their story. | | | | | |
| The meeting allowed the other person to tell their story. | | | | | |
| I think the person who caused the harm understood the impact of the incident on the other person. | | | | | |
| I think the person who was harmed now understands why the other person harmed them. | | | | | |
| The person who caused the harm took responsibility for what they did. | | | | | |
| The meeting gave all participants an opportunity to say how things can be improved and/or repaired. | | | | | |
| I am satisfied with the meeting outcomes. | | | | | |
| The meeting was valuable for the person I supported. | | | | | |
| The meeting was valuable for me personally. | | | | | |
| **Please share any additional comments you may have about the meeting.** | | | | | |
| **I agree to my feedback being shared with the meeting facilitator. YES / NO** | | | | | |

**THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.**
**Please seal it into the attached envelope and return it to the meeting facilitator.**

**APPENDIX 13**

# Restorative Practice in mental health services project evaluation

## Post-meeting questionnaire

Thank you for agreeing to complete this questionnaire, which is part of an independent evaluation of the Restorative Practice in mental health services project currently underway at The Prince Charles Hospital.

You are being asked to complete this questionnaire because you have just participated in a facilitated restorative meeting. We are interested in finding out how well these meetings are working from the point of view of participants.

Please note that the questionnaire does not ask for your name and your answers will be kept confidential; no-one except the researchers will see them.

The questionnaire *should take you no more than 5 minutes to complete*.

Please respond to each statement by ticking the box beside it that best matches your level of agreement with that statement. Please be as honest as you can; we are keen to get your honest opinions, whether they are positive or negative.

To make sure no-one else sees your answers, *please put your completed questionnaire in the attached envelope, seal the envelope and return it to the meeting facilitator*, who will post it to the research team.

---

**PLEASE TURN TO THE OTHER SIDE OF THIS PAGE**

| Statement | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I felt well prepared for the meeting. | | | | | |
| The facilitator managed the meeting well. | | | | | |
| It was easy to understand what was going on. | | | | | |
| The meeting was fair on me. | | | | | |
| The meeting was fair on the other participant/s. | | | | | |
| The meeting allowed me to tell the story of the incident from my perspective. | | | | | |
| The meeting allowed the other participant/s to tell their story. | | | | | |
| The meeting helped all participants to better understand the circumstances that led to the incident. | | | | | |
| The meeting helped all participants to better understand the impacts of the incident. | | | | | |
| The meeting gave all participants an opportunity to say how things can be improved and/or repaired. | | | | | |
| I am satisfied with the meeting outcomes. | | | | | |
| The meeting was valuable for me personally. | | | | | |
| I would recommend a restorative meeting to others who have been involved in incidents where relationships have been harmed. | | | | | |
| **Please share any additional comments you may have about the meeting.** | | | | | |
| **I agree to my feedback being shared with the meeting facilitator. YES / NO** | | | | | |

**THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.**
**Please seal it into the attached envelope and return it to the meeting facilitator.**

**APPENDIX 14**

**Restorative Practice in mental health services project evaluation**

# Would you be interested in participating in a follow-up telephone interview?

If your answer is YES or MAYBE, please read on for more information.

The evaluation of the Restorative Practice (RP) in mental health services project at The Prince Charles Hospital aims to assess the effectiveness of RP in mental health services while also identifying opportunities to improve its implementation.

**Your participation**

As part of the evaluation, the research team hopes to conduct follow-up interviews with people who have participated in a restorative meeting, to gather information about their longer-term satisfaction with the meeting and its outcomes.

You do not need to agree today to participate in a follow-up interview. At this point we are asking only for your contact details and your permission for us to get in touch with you in five to six months time. We would then invite you to participate in a telephone interview at a time that suits you. The interview would be conducted by a member of the research team and would take no more than 20 minutes.

**Your rights**

It is important that you understand that your participation in the follow-up interview is voluntary.

If you decide not to participate, there will be no penalties or other negative consequences.

If you decide to participate, you may discontinue your participation at any time and you do not have to explain your reasons for doing so. You may also ask the research team to destroy any data you have already provided.

All information you provide, either now or during the interview, will be treated as confidential and will be kept securely by the research team. It will be used only for the purposes of the evaluation. Your name and contact details will be stored separately from your responses to the interview questions.

**Benefits**

If you participate in a follow-up interview, we will send you a $30 multi-store gift voucher to thank you for your time and to compensate you for any inconvenience. You may also appreciate the opportunity to reflect on the restorative meeting and its longer-term outcomes. More broadly, the research team hopes that both mental health staff and mental health consumers will benefit from the evaluation over the longer term, as a result of improved knowledge and evidence about the benefits of RP in mental health services and how best to implement it in such contexts.

**Risks**

There are no specific risks associated with your participation in either the follow-up interview or the evaluation as a whole. However, you may find it distressing to be reminded of the incident that led to the restorative meeting. For this reason, you might want to arrange for a supportive friend or family member to be with you during the interview. Also please remember that if you start to feel uncomfortable during the interview, you can discontinue it at any time without prejudice.

**Further information**

The evaluation of the RP project is being conducted by a team of independent consultants led by Dr Diana Beere, who would be glad to answer your questions about the evaluation at any time. You may contact her on 0439 837 783 or at dianabeere@gmail.com. You should also contact her if you want to learn about the findings from the evaluation.

The evaluation plan has been reviewed by The Prince Charles Hospital Human Research Ethics Committee and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018). If you would like to discuss your participation in this evaluation with someone who is not involved in it, you may contact the Research, Ethics and Governance Unit at The Prince Charles Hospital on 07 3139 4500 or at ResearchTPCH@health.qld.gov.au.

**Next steps**

If you are willing to be contacted by a member of the research team in five to six months time, please complete the attached consent form, seal it into the envelope provided and return the envelope to the meeting facilitator, who will mail it to the research team.

You should keep this information sheet in case you want to refer to it in future.

## Restorative Practice in mental health services project evaluation

## Consent to be contacted about a follow-up telephone interview

**Statement**

- I have read the information sheet for potential participants in follow-up telephone interviews, and have been given a copy to keep.
- I understand that I may ask questions about the evaluation at any time, and I know who to contact to do this.
- I understand that my involvement in the evaluation is voluntary and that there is no penalty for not participating, or for changing my mind about participating.
- I understand that I may withdraw from participating in the evaluation at any time without explanation, and may ask the research team to destroy any information I have already provided.
- I understand that any information I provide will be stored and used as described in the information sheet for potential participants.
- I agree to be contacted in five to six months time by a member of the research team and invited to participate in a follow-up telephone interview about the restorative meeting I attended today.

**Name:** _____

**Telephone number:** _____

**Signature:** _____ **Today's date:** _____/_____/_____

**APPENDIX 15**

# Conversation guide for contacting potential participants in follow-up telephone survey

Hello, my name is *[insert name]* and I'm a member of the research team that is evaluating the project to implement Restorative Practice in mental health services at The Prince Charles Hospital.

You might recall completing a questionnaire after attending a restorative meeting about five or six months ago. You also kindly agreed at that time that we could contact you again, to invite you to participate in a follow-up survey. So that's why I've called you today, to see if you're interested in doing the follow-up survey. This one can be done over the phone, at a time that's convenient to you.

Before you agree to participate in this survey, it's important that you understand that you don't have to participate if you don't want to; your participation is voluntary. You should also be aware that even if you decide now that you want to participate, you can change your mind later, and you don't have to explain why. There won't be any penalties or other negative consequences.

If you do participate, your answers to the survey will be kept confidential. We will store them separately from your name and contact details and no-one except members of the research team will see them. The only other person who will know whether or not you participated in the survey will be your support person, if you choose to have one with you.

Please consider asking a support person to be with you during the interview, especially if you think there's a possibility that it will distress you in any way to be reminded of the incident that led to the restorative meeting. We won't be asking you any questions about the incident itself, though; we're only interested in your opinions about the restorative meeting process. And please remember that you can stop the interview at any time.

The survey will take about 25 minutes.

Do you have any questions?

*(Once any questions have been answered)* **Do you agree to participate in the follow-up survey?**

*(If YES, arrange a day and time for the interview, and ask the person to note it in their diary.)* **Thanks very much for that; it will really help us with our research. And to thank you for your time, we'll send you a $30 multi-store gift voucher after the survey is completed. I'll call you again at** *[insert time]* **on** *[insert date]*.

*(If NO)* **That's OK, thanks very much for your time today.**

**APPENDIX 16**

# Follow-up telephone interview questions (person harmed)

**Introductory comments**

Hello, my name is [*insert name*] and I'm a member of the research team that is evaluating the project to implement Restorative Practice in mental health services at The Prince Charles Hospital. This includes evaluating how well restorative meetings are working from the perspective of participants.

You might recall completing a questionnaire after attending a restorative meeting about six months ago. I'll be asking some similar questions in this follow-up interview, because we're interested in your opinions about the restorative meeting experience over the longer term.

Please remember that your answers will be kept confidential, and will be stored separately from your name and contact details. No-one except members of the research team will know whether or not you participated in this interview, and no-one else will see your answers. So I'd appreciate it if you could be completely honest in your responses to my questions.

Please also remember that your participation in the evaluation is voluntary. You may discontinue the interview at any time, without giving a reason. You can also change your mind after this interview, if you wish; at any time before the end of the evaluation project (about April 2022), you can ask us not to use any information you've already given us and you can ask us to destroy that information.

The interview will take about 20 to 25 minutes, and once it's completed, I'll send you a $30 multi-store gift voucher to thank you for your time.

**Do you have any questions?**

(*Once any questions have been answered*) **Are you happy to go ahead with the interview now?**

(*If YES*) **Do you have a support person with you at the moment? If so, may I speak to them for a moment please?** *(If YES, ask the support person to confirm that the person has made an informed decision to participate in the interview. Once this has been confirmed, proceed with the interview. If NO to having a support person, proceed with the interview <u>only</u> if you are confident that the person is participating on the basis of informed consent.)*

*(If NO, not happy to go ahead now)* **Would you like to schedule the interview for another time?**

*(If YES, arrange another time to call.)*

(*If NO*) **That's OK, thanks very much for your time**. *(Discontinue call.)*

**I'd like to begin by asking you to think back to the period leading up to the restorative meeting.**

1. **How satisfied do you feel *now* with how well the facilitator prepared you for the meeting?**

| Very dissatisfied | Slightly dissatisfied | Fairly satisfied | Very satisfied |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

2. **Did you feel at all pressured to attend the meeting?**

| No | Yes |
|---|---|
| 1 | 2 |

*(If NO, skip to Q5.)*

3. **How much pressure did you feel?**

| A little | A fair bit | A lot |
|---|---|---|
| 1 | 2 | 3 |

4. **Who did you feel was pressuring you?** *(Multiple responses possible)*

| Facilitator | Support person | Family member/s | Work-mate/s | Manager | Friend/s | Someone else |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Now I'd like you to think back to the restorative meeting itself.**

5. **How well do you think the facilitator managed the meeting?**

| Very poorly | Somewhat poorly | Fairly well | Very well |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

(If VERY WELL, skip to Q7.)

6. **Was there anything in particular that you think the facilitator could have managed better? If so, please tell me briefly what it was.**

| |
|---|
| |

7. **What aspects of the restorative meeting did you like best?**

| |
|---|
| |

8. **Were there any aspects of the meeting that you didn't like? If so, please tell me what they were.**

| |
|---|
| |

9. **Did you have a support person with you at the meeting?**

| No | Yes |
|---|---|
| 1 | 2 |

*(If NO, skip to Q11.)*

10. **How helpful was it to have a support person attend the meeting with you?**

| Not helpful at all | Somewhat helpful | Fairly helpful | Very helpful |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

*(Skip to Q12.)*

11. **In retrospect, would you have preferred to have a support person attend the meeting with you?**

| No | Yes |
|---|---|
| 1 | 2 |

12. **How fair do you think the meeting was on *you*?**

| Very unfair | Somewhat unfair | Fair | Very fair |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

13. **How fair do you think the meeting was on *the person who harmed you*?**

| Very unfair | Somewhat unfair | Fair | Very fair |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

14. **How satisfied are you with the opportunity you got during the meeting to explain the impact of the incident on you?**

| Very dissatisfied | Slightly dissatisfied | Fairly satisfied | Very satisfied |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

15. **How helpful was it to be able to talk directly with the person who harmed you about the impact of the incident on you?**

| Not helpful at all | Somewhat helpful | Fairly helpful | Very helpful |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

16. **By the end of the meeting, how well do you think the person who harmed you understood the impact of the incident on you?**

| Didn't understand at all | Understood a little | Understood fairly well | Understood very well |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

17. **As a result of the meeting, how well do you understand what was going on for that person at the time?**

| Don't understand at all | Understand a little | Understand fairly well | Understand very well |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

18. **How much responsibility do you feel the person who harmed you took for what they did?**

| No responsibility at all | A little responsibility | A fair bit of responsibility | Full responsibility |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

19. **Did the meeting result in an agreement between you and the person who harmed you?**

| No | Yes |
|---|---|
| 1 | 2 |

*(If NO, skip to Q25)*

20. **How satisfied are you with the amount of input you had into the agreement?**

| Very dissatisfied | Slightly dissatisfied | Fairly satisfied | Very satisfied |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

21. **How fair do you think the agreement was on *you*?**

| Very unfair | Somewhat unfair | Fair | Very fair |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**22. How fair do you think the agreement was on *the person who harmed you*?**

| Very unfair | Somewhat unfair | Fair | Very fair |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**23. How important has it been to you that the agreement is fulfilled?**

| Not at all important | A little important | Important | Very important |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**24. How satisfied are you with the amount of information you've received since the meeting about the extent to which the agreement has been fulfilled?**

| Very dissatisfied | Slightly dissatisfied | Fairly satisfied | Very satisfied |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**25. Did the person who harmed you apologise and/or show remorse for what they did?**

| No, neither | Yes, apologised | Yes, showed remorse | Yes, apologised and showed remorse |
|---|---|---|---|
| 1 | 2 | 3 | 4 |
| *(Skip to Q30)* | *(Go to Q26)* | *(Skip to Q29)* | *(Go to Q26)* |

**26. Have you accepted their apology?**

| No | Yes |
|---|---|
| 1 | 2 |

*(If YES, skip to Q28)*

**27. Why not?**

| Didn't seem sincere | Not sure | Other |
|---|---|---|
| 1 | 2 | 3 |

**28. To what extent did the apology help you feel better about what happened?**

| Not at all | A little better | A fair bit better | A lot better |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

29. *(Only if YES to remorse at Q25)* **To what extent did the fact that they showed remorse help you feel better about what happened?**

| Not at all | A little better | A fair bit better | A lot better |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

30. **To what extent do you feel that participating in the restorative meeting has helped you recover from the harm that was caused to you?**

| Not at all | A little bit | A fair bit | A lot |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

31. **Overall, how satisfied are you with the meeting outcomes?**

| Very dissatisfied | Slightly dissatisfied | Fairly satisfied | Very satisfied |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

32. **If you were involved in a similar incident (one in which you were harmed by another person) how likely is it that you would choose to go through a restorative meeting process, if it was offered?**

| Very unlikely | Somewhat unlikely | Fairly likely | Very likely |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

33. **How likely is that you would recommend restorative meetings to other people who've been harmed by someone else?**

| Very unlikely | Somewhat unlikely | Fairly likely | Very likely |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**That's the end of the survey, so thank you very much for participating. Your answers will greatly assist our research. Before you go, though, I'd just like to make sure you have the contact details for the Queensland Health Victim Support Service, in case you find you need their support after this interview. Do you have a pen and paper handy?** *(If necessary, wait while they get a pen and paper.)* **Their number is 1800 205 005 or you can email them at Victim.Support@health.qld.gov.au.**

**Also, if you are happy to tell me your postal address, I will mail you the $30 gift voucher.** *(Record name and postal address in spreadsheet.)*

**APPENDIX 17**

# Participant information sheet
# Phase 2 face-to-face interviews (staff)

**Project title**

Restorative Practice in mental health services project evaluation

**Purpose of study**

You are invited to participate in an independent evaluation of the Restorative Practice (RP) in mental health services project currently underway at The Prince Charles Hospital. Among other things, the evaluation aims to assess how well RP works in mental health services.

**Your participation**

You are being asked to participate in this evaluation because of your role in implementing the RP project in the Secure Mental Health Rehabilitation Unit (SMHRU) at The Prince Charles Hospital.

Specifically, you are invited to participate in a semi-structured face-to-face interview with a member of the research team, to be conducted at your workplace. The interview will explore your views on the effectiveness of the RP project in the SMHRU, including any benefits it has provided for staff, consumers and the unit as a whole, and any negative consequences. The interviewer will not ask you for any personal information; nor will you be asked to comment on the performance of any particular people involved in the RP project.

With your permission, we will send you a short set of questions by email a few days before your interview. Please note that you are not required to answer these questions in writing; they are intended to help you refresh your memory and clarify your thoughts in preparation for the interview. Some additional questions are likely to be asked at the interview itself.

Again with your permission, we will digitally record your interview and have the recording transcribed by a professional transcription service. If you do not wish your interview to be recorded, the interviewer will make handwritten notes instead.

**Your rights**

It is important that you understand that your participation in the evaluation is voluntary.

If you decide not to participate, there will be no penalties or other negative consequences.

If you decide to participate in the evaluation, you also have the right to change your mind. You may discontinue your participation at any time before the evaluation is completed (approximately June 2022), and you may do so without providing any explanation. You may also request the research team to withdraw and destroy any information you have already provided. All information you

provide — including the digital recording, the transcription, and any handwritten notes taken by the interviewer — will be treated as confidential and will be kept securely by the research team. It will be used only for the purposes of the evaluation. Your name will be replaced by a unique code to protect your identity.

You have the right to ask questions about the evaluation procedures and to have them answered. If you have any questions, please ask them before the interview begins.

**Benefits**

While there are no direct benefits to participating in this evaluation, you may enjoy the opportunity to discuss and reflect on the outcomes of the RP project, both positive and negative. More broadly, both mental health staff and mental health consumers will benefit in the longer term from improved knowledge and evidence about the benefits of RP in mental health services and how best to implement it in such contexts.

**Risks**

There are no specific risks associated with your participation in either this interview or the evaluation as a whole. However, if you have previously been harmed by a mental health consumer, it is possible, albeit unlikely, that you may find the interview upsetting, so you might like to have a support person attend the interview with you. Either way, if you find you are becoming uncomfortable you can discontinue the interview at any time without prejudice.

It is important that you understand that, in a small study such as this, we cannot guarantee to protect your identity. To the extent possible, in reporting the findings of the study we will avoid referring to individual people we have interviewed; if we need to mention individuals, we will do so by using a pseudonym and/or a generic position title. However, there remains a risk that you will still be identifiable to readers, particularly colleagues with knowledge of the RP project.

**Further information**

The evaluation of the RP project is being conducted by a team of independent consultants led by Dr Diana Beere, who would be glad to answer your questions about the evaluation at any time. You may contact her on 0439 837 783 or at dianabeere@gmail.com. You should also contact her if you want to learn about the findings from the evaluation.

The evaluation plan has been reviewed by The Prince Charles Hospital Human Research Ethics Committee and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018). If you would like to discuss your participation in this evaluation with someone who is not involved in it, you may contact the Research, Ethics and Governance Unit at The Prince Charles Hospital on 07 3139 4500 or at ResearchTPCH@health.qld.gov.au.

# Participant consent form
# Phase 2 face-to-face interviews (staff)

**Project title**

Restorative Practice in mental health services project evaluation

**Statement**

- I have read the Participant Information Sheet for this project, and have been given a copy to keep.
- I have been given an opportunity to ask questions about the evaluation.
- I understand that my involvement is voluntary and that there is no penalty for not participating, or for changing my mind about participating.
- I understand that I may withdraw from participating in the evaluation at any time without explanation, and may ask the research team to destroy any information I have already provided.
- I agree to participate in the evaluation and for information provided by me to be stored and used as described in the Participant Information Sheet.

**Name:** _____

**Signature:** _____ **Today's date:** _____/_____/_____

**APPENDIX 18**

# Restorative Practice in mental health services project evaluation
# Phase 2 face-to-face interviews (staff)

## Question guide

10. Please tell me how long you've worked in the Secure Mental Health Rehabilitation Unit (SMHRU) at The Prince Charles Hospital. It doesn't matter if you can't tell me exactly how long; I'm mainly interested in whether or not you were working in the SMHRU before the implementation of Restorative Practice (RP).

11. Please tell me about your experience with RP in the SMHRU. For example, have you used restorative dialogue or observed it being used by others? Have you been involved in restorative circles? Or have you referred anyone for restorative conferencing or participated in a restorative conference yourself?

12. RP was introduced in the SMHRU as an additional option for responding to incidents where someone has caused harm or threatened harm to someone else. How useful has it been, in your opinion? Please tell me the reasons for your answer.

13. Has the introduction of RP in the SMHRU made a difference for you personally? If so, please tell me about the ways in which it has made a difference for you.

14. In your opinion, has the introduction of RP made a difference for other staff in the SMHRU? If so, in what ways do you think it has made a difference for them?

15. In your opinion, has the introduction of RP made a difference for consumers in the SMHRU? If so, in what ways do you think it has made a difference for them?

16. One of the aims of the RP project has been to establish the SMHRU as a 'restorative ward'. Would you say that aim has been achieved yet? Please tell me the reasons for your answer.

17. What differences, if any, do you think the introduction of RP has made to the SMHRU as a whole?

18. In your opinion, have there been any negative consequences of introducing RP in the SMHRU? If so, please tell me what you think they are.

19. Is there anything else you would like to say about the benefits or otherwise of implementing RP in the SMHRU?

**APPENDIX 19**

# Participant information sheet
# Phase 2 face-to-face interviews (consumers)

**Project title**

Restorative Practice in mental health services project evaluation

**Purpose of study**

You are invited to take part in an independent evaluation of the Restorative Practice (RP) in mental health services project at The Prince Charles Hospital. Among other things, the evaluation is looking at how well RP works in the Secure Mental Health Rehabilitation Unit (SMHRU).

**Your participation**

You are being asked to participate in this evaluation because you are currently a resident of the SMHRU.

Specifically, you are invited to take part in an interview with a member of the research team. The interview will be about what you think about RP, including whether you think it has done any good for you or for other consumers or for the SMHRU as a whole. The interviewer will also ask about whether you think there is any down-side to RP.

If you decide to participate, we will give you a list of the questions a few days before your interview, so that you have time to think about your answers. Depending on what your answers are, the interviewer might ask some extra questions at the interview. You won't be asked for any personal information.

The interviewer will make a recording of what you say at the interview, if you agree to this. A professional transcription service will then use the recording to make a written record of what you have said. If you do not want your interview to be recorded, the interviewer will write down what you say instead.

**Your rights**

Please note that you don't have to participate in the interview if you don't want to. You have the right to say no, and you don't have to tell us why.

If you decide you don't want to be interviewed, it won't be held against you. You won't be treated any differently.

If you decide to participate in the interview, you have the right to change your mind either during the interview or after it has finished. You can change your mind at any time before the evaluation is completed (approximately June 2022), and you don't have to give a reason. You can also ask the

research team not to use anything you've already told the interviewer and to destroy the interview records.

All the interview records — including the recording, the written record, and any handwritten notes taken by the interviewer — will be treated as confidential. We will keep them in a secure place so that no-one else can see what you've told us. We won't write your name on any of the interview records, and we won't use them for anything except the evaluation of the RP project.

You have the right to have a support person, such as a Recovery Assistant, with you during the interview, and you are encouraged to so.

You also have the right to ask questions about the evaluation and to have them answered. If you have any questions, please ask them before the interview begins.

**Benefits**

If you decide to go ahead with the interview, we will give you a $30 multi-store gift voucher at the end of the interview to thank you for your help. Both mental health staff and other mental health consumers will also benefit in the longer term from better knowledge about how well RP works in mental health services.

**Risks**

There are no specific risks involved in taking part in this interview. However, it is important that you understand that, because this is a small study, we cannot guarantee to protect your identity, although we will make every effort to do so. When we report the findings of the study, we will not use your name; instead, if we need to mention you, we will use another name or refer to your role in the study. However, there is a small risk that you will still be identifiable to readers of the report, particularly SMHRU staff and consumers.

Please remember that if you begin to feel uncomfortable you can stop the interview at any time.

**Further information**

The evaluation of the RP project is being conducted by a team of independent consultants led by Dr Diana Beere, who would be glad to answer your questions about the evaluation at any time. You may contact her on 0439 837 783 or at dianabeere@gmail.com. You should also contact her if you want to learn about the findings from the evaluation.

The evaluation plan has been reviewed by The Prince Charles Hospital Human Research Ethics Committee and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018). If you would like to discuss your participation in this evaluation with someone who is not involved in it, you may contact the Research, Ethics and Governance Unit at The Prince Charles Hospital on 07 3139 4500 or at ResearchTPCH@health.qld.gov.au.

# Participant consent form
# Phase 2 face-to-face interviews (consumers)

**Project title**

Restorative Practice in mental health services project evaluation

**Statement**

- I have read the Participant Information Sheet for this project, and have been given a copy to keep.
- I have been given an opportunity to ask questions about the evaluation.
- I understand that my involvement is voluntary and that there is no penalty for not participating, or for changing my mind about participating.
- I understand that I may stop participating in the evaluation at any time without explanation, and may ask the research team to destroy any information I have already provided.
- I agree to participate in the evaluation and for information provided by me to be stored and used as described in the Participant Information Sheet.

**Name:** _____

**Signature:** _____ **Today's date:** _____/_____/_____

**Witnessed by (name):** _____

**Signature:** _____ **Today's date:** _____/_____/_____

**APPENDIX 20**

# Restorative Practice in mental health services project evaluation
# Phase 2 face-to-face interviews (consumers)

## Question guide

1. Please tell me how long you've been here in the Secure Mental Health Rehabilitation Unit (SMHRU) at The Prince Charles Hospital. It doesn't matter if you can't tell me exactly how long; I'm mainly interested in whether or not you were here before the introduction of Restorative Practice (RP).

2. Have you been involved in a restorative conversation following an incident when someone — either you or someone else in the SMHRU — has harmed or threatened to harm someone else? Or have you noticed restorative questions being used by staff in a situation like that? If so, can you tell me how useful you think RP was in those situations?

3. Have you been involved in any restorative circles? If so, how useful have those circles been for you? And how useful do you think those circles have been for the other people involved?

4. Have you been through a restorative conferencing process? If so, can you please tell me about that experience and whether or not you found it helpful?

5. Has the introduction of RP in the SMHRU made a difference for you personally? If so, please tell me about the ways in which it has made a difference for you.

6. In your opinion, has the introduction of RP made a difference for other consumers in the SMHRU? If so, in what ways do you think it has made a difference for them?

7. In your opinion, has the introduction of RP made a difference for staff in the SMHRU? If so, in what ways do you think it has made a difference for them?

8. What differences, if any, do you think the introduction of RP has made to the SMHRU as a whole?

9. In your opinion, has there been any down-side to using RP in the SMHRU? If so, please tell me about it.

10. Is there anything else you want to say about RP and how well it's working in the SMHRU?