# Low and Medium Secure Forensic Services

## Restorative Practice: Repairing harm
### A response to patients who have caused harm

# Procedure

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**CONTENTS**

## 1. INTRODUCTION

1.1 Restorative justice is a process in which victims (a person harmed) and perpetrators (the harmers) come together in a controlled environment, to communicate about a wrong doing (National Perpetrator Management Service, 2013). In a face to face meeting they are supported by a trained facilitator to talk about the harm that has been caused and find a way to repair that harm. Restorative Justice aims to allow each person to process and share how they are feeling through helpful communication, relationship building, and communication of moral values.

1.2 Restorative justice has been found to benefit both the harmed and harmers. For the harmed the process has been shown to;

i. Offer a process in which they can reach a sense of closure and reassert some control over their situation.
ii. It allows them to tell the harmer the real impact of their act, get answers to their questions and also get an apology.
iii. The process has also been found to empower the harmed by giving them a voice.

1.3 With regard to the harmers the process has been shown to;

i. Give them the chance to reflect more on the impact of their behaviour.
ii. Offer them an opportunity to think about and relearn how they might behave in the future.
iii. It also holds them to account for what they have done and helps them to take responsibility and make amends.

1.4 There are six key principles to restorative justice (Restorative Justice Council, 2020) and it is these principles that guide the intervention;

i. Restoration: The primary aim of restorative practice is to address and repair harm.
ii. Voluntarism: Participants come to a restorative intervention of their own free will, having understood the reasons and process. It is the duty of the practitioner to ensure that everyone taking part understands why they are there and their responsibilities in relation to the process.
iii. Impartiality: Restorative Practitioners remain impartial and ensure their restorative practice is respectful, non-discriminatory and unbiased towards all participants.
iv. Safety: The safety of all participants needs to be ensured at all times. It is the role of the facilitator to create a safe space for the expression of feelings and views about harm that has been caused. This includes practitioners being appropriately trained.
v. Accessibility: Restorative processes are non-discriminatory and should be available to all those affected by conflict and harm.
vi. Empowerment: Restorative practice must support individuals to feel more confident in making their own informed choices to find solutions and ways forward which best meet their needs.

## 2. The evidence base

2.1 Grounded in Braithwaite's (1989) theory of reintegrative shaming (as opposed to stigmatisation), Restorative Justice has a strong theoretical underpinning, other practitioners including Sherman (1993), Tyler and Huo (2002) and Braithwaite (2002) have since developed this theoretical concept. Based partly on evaluations of Restorative Justice Conferences, Collins (2004) developed a causal model around the intense emotions triggered by such meetings and the subsequent impact on behavioural change. Furthermore, Yantzi (1998, cited in Gavrielides, 2015) has claimed that the healing process for victims can be helped by offenders taking ownership of their behaviour, without making excuses.

2.2 The practice of Restorative Justice has become increasingly popular over the past 35 years (Centre for Justice and Reconciliation) and has been widely adopted by the criminal justice system and schools. In response to this there has been developing interest in its application leading to a growing database of research within the last 20 years.

2.3 In 2001, the government funded a seven year research programme into restorative justice, four reports were published by Shapland, et al (2004; 2006; 2007; 2008). The results revealed Restorative justice to provide an 85% victim satisfaction rate with the majority of victims choosing to participate in face to face restorative meetings with their perpetrator; face to face conferences were found to be most effective. With regard to offender outcomes there was a 14% reduction in the frequency of reoffending. Furthermore, the intervention saved money by diverting people away from prosecution and by reducing reoffending.

2.4 Strang, Sherman, Mayo-Wilson, Woods, & Ariel (2013) completed a systematic review of 10 published papers exploring the use of restorative justice. They found that restorative justice conferences appeared to reduce future detected crimes. They did highlight however, the need to think about the kinds of perpetrators who are willing to consent to restorative justice conferences, and whose victims were also willing to consent; as this may influence the direction of such outcomes. In support of earlier findings they also found victims' satisfaction with the handling of their cases was consistently higher for victims assigned to restorative justice conferences than for victims whose cases were assigned to normal criminal justice processing.

2.5 With regard to its therapeutic value Angel et al (2014) examined the impact of face to face restorative justice meetings on symptoms of post-traumatic stress for victims of burglary and robbery. Their findings suggested that restorative justice conferences reduce clinical levels of post-traumatic stress symptoms in a short-term follow-up assessment.

2.6 Restorative practices can be extended to the whole environment and used in anticipation of conflict, where this has been applied to school and residential settings for children with complex emotional needs and behavioural difficulties, it has been largely successful (Littlechild, 2011; Preston, 2015).

## 3. Restorative practice in forensic mental health settings

3.1 Whilst there is a growing populous of research in prison and community criminal justice settings, unfortunately the research in mental health settings remains limited. Liebmann (2007) reported on one case study and in her conclusions advised against the use of restorative justice. However, there was limited analysis in her report regarding how the mental health problems may have impacted upon the intervention.

3.2 Cook, Drennan & Callanan (2015) explored the experience of restorative justice approaches in a forensic mental health setting. The types of restorative justice cases they included were; patient/staff conflict, index offences (preparatory work), inappropriate sexual behaviour towards staff and assaults towards staff. They showed restorative interventions helped to work toward the therapeutic goals of the service and participants reported high levels of victim and perpetrator satisfaction. Furthermore, restorative justice supported with offence paralleling behaviour, victim empathy, preparing for discharge, awareness of self, perpetrator & mental health recovery and preparatory work offered value even where this did not lead to a restorative justice conference. Some limitations were also noted, including the small sample and the early stage of implementation they were at; index offence conferences had not yet been completed.

3.3 In a later study Cook (2019) concluded how restorative interventions positively impacted on the therapeutic environment on wards and complimented existing treatment regimes. Furthermore,

Tapp, Moore, Stephenson and Cull (2020) demonstrated how restorative practices could safely be applied within a secure hospital setting and could be followed by a person with difficulties in social and emotional processing. Cooper et al (in preparation) explored how applying restorative principles to daily practice in a low secure forensic unit contributed to improvements approaching statistical significance in measures of therapeutic hold, patient cohesion, and experienced safety, as well as a reduction in harms experienced on the unit (Cooper and Whittingham (2022).

## 4. Rationale and aims

4.1 Patients and staff in inpatient settings are at an increased risk of exposure to violent and harmful events (Bowers et al, 2011). Such incidents can have a negative impact on patient and staff mental well-being and on subsequent patient and work experiences. Current responses within the service address the needs of individuals; yet they fail to address the violation that has occurred between these individuals; restorative practice will bridge this gap.

4.2 Research on the merits of Restorative Justice is expediential and its application in forensic mental health settings is growing. The approach has been shown to add value in a number of ways.

i. Restorative Justice will help to reduce harm, build relationships, and facilitate helpful dialogues.
ii. It offers victims a process in which they can reach a sense of closure and reassert some control over their situation.
iii. Restorative justice allows a perpetrator to reflect more greatly on the impact of their behaviour and relearn how they might behave in the future.
iv. Restorative justice can support with therapeutic processes, including offence paralleling behaviour, victim empathy, preparing for discharge, awareness of self, perpetrator & mental health recovery.

4.3 **Restorative Practices** will aim to become an integral part of the therapeutic programme offered to patients. Harmers must feel engaged and invested in the Restorative process to maximise the likelihood of a positive outcome for them and those they have harmed. To ensure the safe practice of this process and guided by the National Perpetrator Management Service, 2013 Paper; *Wait 'til Eight. An essential start up guide to MONS RJ Scheme implementation*, the current procedure has been developed. The programme aims to have equal responsibility for the restoration of both harmers and the harmed and includes both direct and indirect processes which are tailored to the needs of participants.

4.4 **Restorative Wards:** Where restorative conferences offer benefits to both the harmed and harmer (Cook et al, 2015) it is not always appropriate or safe to move forward with one (National Offenders Management Service, 2013; Cooper & Inett, 2018; Cooper & Whittingham, 2022). Within inpatient settings individuals present with diverse needs and levels of readiness, impacting on their capacity to engage with more formalised restorative practices (Cooper & Inett, 2018; Cooper & Whittingham, 2022). In response to these challenges the concept of a 'restorative ward' was developed (Cooper, Craster, & Inett, in preparation; Cooper and Whittingham, 2022). Outcomes of an initial pilot demonstrated improvements approaching statistical significance in measures of therapeutic hold, patient cohesion, and experienced safety, as well a reduction in harms experienced on the unit (Cooper et al., in preparation). The aim of a 'restorative ward' is to create an environment which fosters awareness, empathy and responsibility, where informal restorative practices become a part of everyday life (McCold & Wachtel, 2001).

4.5 **Equality, Diversity and Inclusion:**
Restorative Practices play a key role in how the low secure forensic service respond to and tackle racism and other forms of prejudice. Restorative principles underpin the tackling racism procedure which is in development and have formed the foundation for other interventions including an

active ally group which has been piloted on one ward and is now being rolled out across the low-secure forensic service.

## 5. THE PROCEDURE

5.1 To reflect the wide spectrum of restorative practices within the service the procedure has been split into two parts; restorative wards and restorative conferencing.

### 5.2 Restorative Wards:

Restorative ward working is being rolled out across the low-secure forensic service, as each ward is trained the procedures described below must be followed;

5.2.1 All ward staff will attend a two-day course on implementing informal restorative practices. Training will be provided by trained facilitators and covers;

- What Restorative practice is and its application to forensic settings
- The Restorative Practice Procedure for KMPT forensic services
- The role of restorative practice in addressing racism.
- Restorative practice process (Restorative Conferencing)
- The Social Discipline Window
- The ethos and aims behind Restorative wards.
- Skills practice in affective statements, restorative questions, restorative conversations, restorative circles
- Restorative care planning & Positive Behaviour Support
- Restorative language (CPA's, ward rounds)
- Managing patient resistance

5.2.2 Following completion of the training all ward staff are offered fortnightly 1-hour supervision sessions creating opportunities for reflection and skills development.

5.2.3 On successful completion of the training, attendees will be accredited as restorative champions. Restorative champions are expected to promote restorative working across the ward, adopt an empathic and non-judgemental position in all their interactions with patients and colleagues. They will create opportunities to build relationships through the use of affective statements and through their attendance at restorative circles. Where harms have occurred they will ensure the harmed and harmer get the most from restorative interventions and that dialogue is meaningful and restorative, they will provide a safe space for this to happen. The role of ward based restorative champions includes;

- Offer informal restorative practices including affective statements, restorative questions and conversations.
- Attend and support the facilitation of restorative circles.
- Support in the development and updating of individualised restorative care plans.
- Attend fortnightly restorative supervision.
- Follow the Restorative Practice procedure; promote Restorative practice across the service, upholding its principles and values.
- Accurately record and store information as per Trust policy on Clinical Governance.
- Share learning and identify good practice, this may be through attending other events, training others about this approach, providing regular written briefings and organising Restorative Practice events within the Trust.
- Contribute to audit, research and development, assisting in the evaluation of Restorative Practice Interventions.

## 5.3 Restorative Conferencing

5.3.1 **Restorative Practice Team (RPT):** The RPT is a working party, within KMPT Low and Medium Secure Forensic Services and the Learning Disability, Forensics Outreach Liaison Service (LD-FOLS) made up of Restorative Justice Practitioners. The practitioners include trained Facilitators and Champions. A small number of facilitators will be accredited (or working towards accreditation) with the Restorative Justice Council's Accredited Practitioner Register.

5.3.2 The Psychology team within the Low Secure Forensic Service will be responsible for leading on the scheme and driving it forward. They will be supported by the Psychology team within the Medium Secure Forensic Service and the LD-FOLS team.

5.3.3 **Restorative Practice Facilitators:** The role of a facilitator is to adopt an empathic and non-judgemental position to ensure the harmed and harmer get the most from a face to face meeting and that the dialogue is meaningful and restorative. Where face to face meetings are not possible, facilitators will work closely with participants to offer other restorative interventions (see section 7.6.5). Facilitators will provide a safe space for interventions to take place and will maintain good communication with all participants, coordinating the restorative process from receipt of referral to closure. Their role would entail the following:

- Offer Restorative Interventions across the low and medium secure forensic services and LD-FOLS team, as required, and make sure it is proposed in every eligible and suitable case.
- Support in the promotion and implementation of restorative wards where this applies.
- Follow the Restorative Practice procedure; promote Restorative practice across the service, upholding its principles and values.
- Review and follow the LD-FOLS procedure (in preparation) for additional guidance around community working.
- Support Restorative Practice Champions.
- Attend monthly Restorative Practice Referral meetings and Peer Supervision.
- Accurately record and store information as per Trust policy on Clinical Governance.
- Attend CPD events to maintain and develop restorative facilitator skills.
- Share learning and identify good practice, this may be through attending other events, training others about this approach, providing regular written briefings and organising Restorative Practice events within the Trust.
- Contribute to audit, research and development, assisting in the evaluation of Restorative Practice Interventions.

5.3.4 <u>Skills, abilities, personal qualities:</u>

Restorative Practice Facilitators are required to have completed an accredited four-day restorative justice Facilitator training programme. Staff eligible for the training includes:

- Qualified health professionals; Occupational Therapists, Psychologists, Psychiatrists, Speech and Language Therapists, Social Workers, Registered Nurses.
- Staff working towards qualified status and/or are able to demonstrate experience in offering therapeutic interventions, or demonstrate the right qualities for restorative working (for example Forensic Psychologists in Training/Assistant Psychologists/Health Care Workers).
- Staff who hold a permanent contract within the Low and Medium Secure Forensic Services and LD FOLS team.

5.3.5 Trained restorative justice Practitioners must demonstrate the knowledge and skills outlined in the Best practice Guidance for Restorative Justice (Restorative Justice Council, 2020).

5.3.6 **Restorative Practice Champions:** Restorative Practice Champions are promoters of Restorative Practice who are linked to the RPT and able to promote Restorative Practice to colleagues and

support the referral processes. Any permanent member of staff may apply to be a Champion. Their role would entail the following:

- Answering questions and seeking clarification regarding the Restorative Practice process.
- Identifying relevant diversity needs.
- Motivating and supporting participants in between formal Restorative Practice sessions.
- Identifying and highlighting risks, e.g., underlying attitudes suggesting re-victimisation.
- Support during the conference for the harmed and harmer and supporting the harmer to take forward the outcome agreement.
- Where appropriate attend monthly referral and supervision meetings.
- Support Restorative Practice Reps.

5.3.7 Restorative Practice Champions will be required to attend in-house training (delivered by Trained Facilitators), informing them of the principles and application of Restorative Practice, including skills practice, the process, their role and its application in the low and medium secure forensic services.

5.3.8 **Restorative Practice Reps:** Restorative Practice Reps will be promoters of Restorative Practice, who are linked to the RPT and have lived-in experience. Their role would include informing patients about what Restorative Practice can offer and supporting peers going through the restorative process. Restorative Practice Reps will be supported by Champions and Facilitators. They will be offered training sessions on the principles and processes of Restorative Practice, enabling them to effectively perform this role. This role is in development and will be further defined in due course.

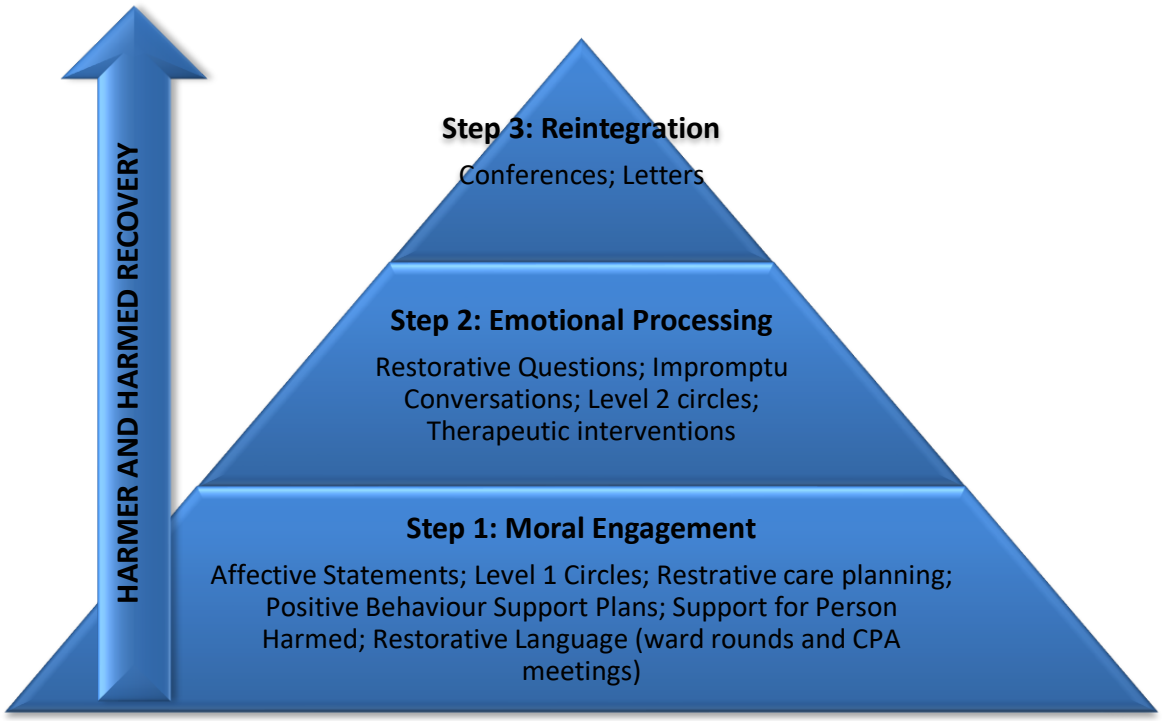
5.3.9 **Partnership working:** Where both parties have consented to a restorative intervention and the harmed has also reported the incident to the police, restorative practice facilitators will follow the process described below (section 7.2.6). Where it is assessed to be appropriate to move forward with the case, facilitators will assess the merits and possibilities of working in partnership with Kent police in delivering the intervention; with one facilitator from KMPT's RPT and the other from Kent Police. This will ensure the legal requirements can be met and managed by the police and the therapeutic needs of those involved can be met by the Trust. Records will be stored separately by the two services, allowing Kent Police to continue utilising their documentation for Restorative Practice and KMPT to utilise theirs. Legal processes will take the priority, ensuring any evidence needed for criminal proceedings does not become contaminated in any way.

5.3.10 Guidance from the Trust policy regarding partnership working with Kent Police, 'Police Involvement with Mental Health in-patient's policy' should be followed where a partnership restorative practice intervention is offered. If the person harmed chooses not to inform the police and there is no reason for police to be informed by other parties (see Police involvement with mental health in-patient's policy, KMPT, 2015), a restorative practice intervention will be offered internally by trained Restorative Practice Facilitators from the Low and Medium Secure Forensic Services and LD-FOLS team.

5.3.11 Where a member of the public has been harmed by a patient, or restorative practice is being considered in response to a patient's index offence, partnership working with Kent Police and other agencies such as victim support and/or probation, will need to be employed. This will help ensure victims not linked to KMPT have access to appropriate support throughout the process and the process is not felt to be biased in any way. Where external services are not used, the rationale for this would need to be carefully documented and agreed in peer supervision.

## 6. THE PROCESS

### 6.1 Restorative wards map:




### 6.2 STEP 1: Moral Engagement:

Step 1 provides a foundation where patients are supported to engage in processes that enable them to reflect on their behaviour in a meaningful way; the approach humanises those who have been harmed and provides a culture which encourages ownership of behaviour. For those who have been harmed, step 1 offers validation to their experience.

6.2.1. **Affective Statements** let a person know how we feel and how we are affected by their actions, without judgement. They separate the behaviour from the person; acknowledging the persons strengths, whilst saying the behaviour is not okay. They can be used to express both pleasant and unpleasant feelings, acknowledging success and other desirable behaviours, as well as undesirable behaviours. Affective statements should be said in private, away from others, the whole statement may be used or parts of the statement, depending on the patient's capacity to engage.

i. State what you **observe** without judgement or evaluation
ii. State how *you* **feel** about this action
iii. Connect your feelings with **your needs**
iv. Expressing a **request**

6.2.2 **Level 1 Circles** provide opportunities to enhance communication and build a sense of community (Costello et al, 2009) by building relationships between staff and patients and develop peer support. Circles aim to; provide opportunities to hear patient voices and to 'tune in' to their thinking and responses; support patients learn the skills of empathy; allow patients to see others hold different views to their own in fun and non-confrontational ways;; encourages patients to reflect on their behaviour; allow patients to identify personal goals for improvement and can promote opportunities for patients to support one another in achieving goals. There is a gradual shift in responsibility for discipline from staff to patients.

- Patients and staff sit in a circle, so each person can see the face of every speaker.

- Everyone in the circle is given equal opportunities to speak and there is a commitment to listen to one another's views.
- The whole ward agrees to a contract of ground rules facilitating open discussion.
- All staff and patients are invited to get involved; attendance by patients is voluntary. Staff are encouraged to attend and are expected to act as role models.
- Fortnightly supervision sessions will be used to assess patient engagement, identify circle themes and support the development of skills in facilitating circles.
- Following the identification of circle themes, session plans will be created by lead restorative practice facilitators. The session plans can be implemented by other facilitators and trained champions.
- Circles will be evaluated through supervision sessions and circle sessions.
- Circles are a brief intervention (15 minutes), the frequency of which will be determined by the needs of the ward and agreed by ward staff and patients.
- Where more complex issues arise, additional circles may be facilitated, offering more time to explore issues affecting the ward.

6.2.3 Circle structure:

i. Introductory phase (none threatening, giving everyone a voice)
   - Warm up games / Rounds.

ii. Middle phase
   - Circle discussions: Themes may include, but are not limited to; building relationships, exploring how we and others are affected by the actions of others, emotional regulation, empathy, perspective taking and problem-solving skills.

iii. Closing phase
   - Activities to lighten the mood, assess mood, and thank all for contributions.

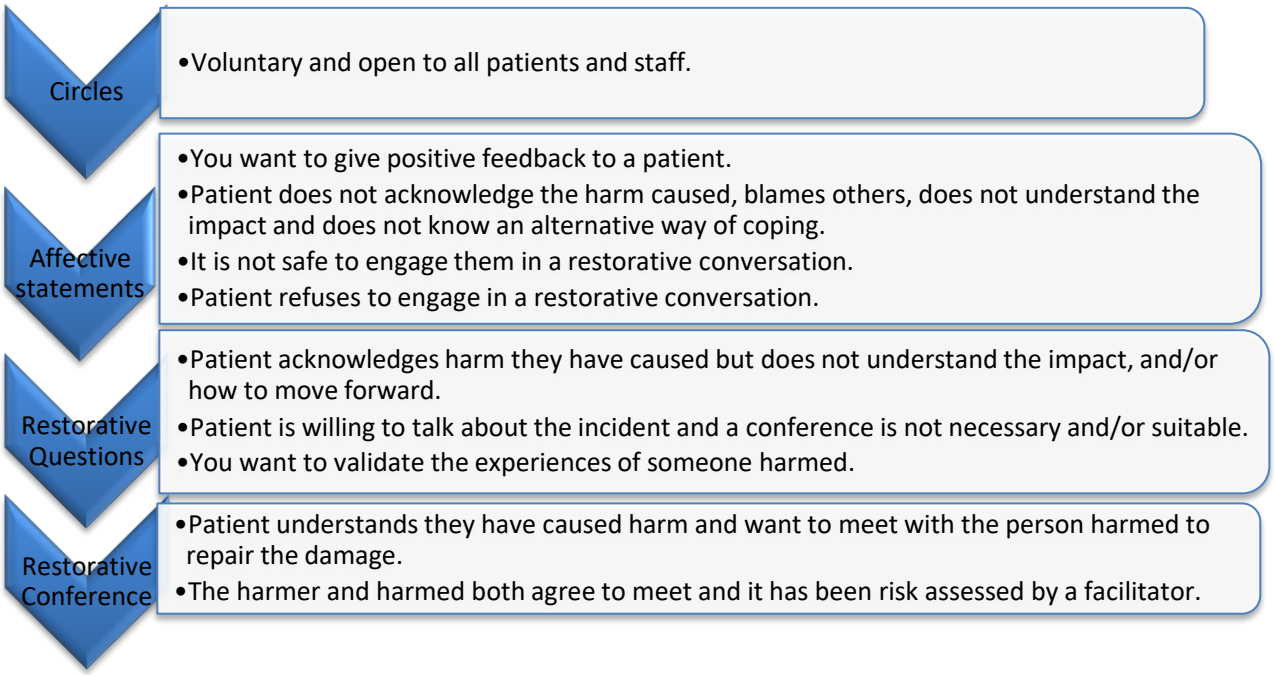
6.2.4 Role of the circle facilitator: To steer circle discussions, support all members make equal contributions and ensure rules are upheld. Circle facilitators are expected to;

- Maintain an upbeat and positive approach.
- Ask questions and share views/experiences to stimulate ideas for discussion.
- Remain neutral.
- Follow session plans with flexibility. Questions on session plans are a guide and can be deviated from where the facilitator assesses this to be appropriate.
- Where facilitators are new to this way of working, they may be supported by co-facilitators helping fill spaces and guide discussions if they become stuck.
- When summarising, it is the role of the facilitator to feedback patient and staff ideas that came from discussions, not what the facilitator wants to see happen.

6.2.5 **Care Planning:** Patients present with different risks and strengths and as such will have individualised care plans detailing how to safely engage them restoratively. Care planning forms a part of the restorative wards training programme, during which staff will be asked to develop care plans for each patient, which will then be shared with the patient before being finalised. Care plans will be developed by considering the following factors;

- The challenges presented by the patient and the approaches used in response.
- Using the 'social discipline window' to identify ways of moving towards (and developing) more collaborative working.
- Identifying need by assessing the patient's capacity to accept responsibility, their capacity to understand the impact of their behaviour and their ability to rebuild relationships.
- Assess any risk factors that may limit theirs or others opportunities to engage with restorative interventions safely.
- Naming restorative interventions that may safely be used with the patient and any caveats.
- Restorative care plans will be reviewed every 6 months, or sooner where the need is identified.

6.2.6 The table below provides a framework for when to consider using the different restorative interventions with a patient.




6.2.7 **Positive Behaviour Support Plans:** Details from care plans will be incorporated into positive behaviour support plans, helping ensure a consistent approach.

6.2.8 **Support for the person harmed:** See restorative questions and impromptu restorative conversations below (Sections 6.3.1, 6.3.2, 6.3.3, 6.3.5)

6.2.9 **Restorative Language (ward rounds and CPA meetings):** Fortnightly restorative supervision and reflective practice forums will be a space to consider how all staff interact and relate to patients. Time will be taken to consider the language and approach used in response to harms done, ensuring restorative principles continue to be upheld and followed.

## 6.2 STEP 2: Emotional Processing:

Step 2 supports patients to consider in a safe and non-judgemental manner the impact of their behaviour, developing victim empathy and supports the development of social problem-solving skills. For the person harmed, step 2 will provide a space to feel and be empowered, they can express to the harmer the true impact of their actions and ask questions.

6.3.1 **Restorative Questions:** Restorative questions offer a format to structure difficult conversations helping individuals understand where harm has occurred, the impact it has had and what can be done to make amends. For the person who caused harm it helps them learn about the impact of their behaviour and encourages increased responsibility. For the person harmed, their experiences are validated. The person harmed and the harmed may be asked these questions separately and away from one another. 6 simple questions are used.

- Questions to the harmer;
  i. What happened?
  ii. What were you thinking at the time?
  iii. What have you been thinking since?
  iv. Who was affected by what you did?
  v. In what way have they been affected?
  vi. What do you think needs to happen to make things right?

- Questions to the harmed;
    i. What happened?
    ii. What were you thinking at the time?
    iii. What have you been thinking since?
    iv. How has this affected you and others?
    v. What was the hardest thing for you?
    vi. What do you think needs to happen next?

6.3.2 Restorative questions may be used as;

- Brief impromptu interventions.
- In response to minor incidents of harm.
- Where the environment and risk has been assessed as safe to proceed (individualised care plans should be consulted).
- Participants are willing.

6.3.3 There are times restorative questions should not be used, including;

- At times patients are highly aroused.
- Patients and/or staff are unable, unwilling or unsuitable to engage.
- If there are wider issues to consider.

6.3.4 Affective statements may be used where the patient is unable or unwilling to engage with restorative questions.

6.3.5 **Impromptu conversations:** Where it is assessed as safe to do so and all parties are willing, the harmer and harmed may come together to be asked the restorative questions (see above).

6.3.6 **Level 2 circles** are used in response to incidents of harm, they provide opportunities for the harmers to reflect on their behaviour (whether they admit it or not) and may influence their future actions as they consider the impact of their behaviour, through their own (and others) shared experiences. Level 2 circles will provide a space for those harmed to voice their concerns and have their experiences validated by their peers.

6.3.7 Level 2 circles will be led by more experienced facilitators (those that have completed the accredited four day training programme). They will be facilitated at a time patients and staff are ready to engage in more challenging dialogues; the ward would have begun to build a sense of community and trust, and all parties who were involved in the harms experienced would have consented to the circle discussion.

6.3.8 The circle may be used when harm has occurred but it is not known who has caused the harm and it is unlikely anyone will accept responsibility. Circles may also be used where there is a pattern of problem behaviour and many patients may have a role in causing the harm and being at the receiving end (e.g. ongoing name calling, telling lies about others, exchanging items/goods).

6.3.9 When only one or two individuals are involved in an incident, it would be better to use other restorative approaches (restorative questions, impromptu meetings, conferences). The exception to this rule would be if the harmer brings the issue to a circle to reflect on his behaviour (thinking about his recovery) and all other parties affected by the incident consent to discuss the incident; the facilitator needs to risk assess the situation and use clinical judgement to determine if it is safe and appropriate to go ahead.

6.3.10 The structure mirrors that for level 1 circles (see section 6.2.3), but may be longer in time to allow for greater exploration of participants experiences and resolution of harms encountered (see section 6.2.2).

6.3.11 **Therapeutic interventions:** Restorative principles may be built into other psychological treatment programmes, including individual and group therapy. The aim would be to deliver more accessible ways to support the development of offender recovery. Examples include;

- Individual offender-based treatment where videos of victims' experiences have been shared to help the harmer learn more about the impact of their offence.
- Family therapy sessions to support patients and their families work through and understand the traumas experienced and explore ways to move forward as a family.
- Offender based groups which have been developed with restorative principles laying the foundation for the programme; e.g. the active ally programme.

## 6.4 STEP 3: Reintegration:

The final step supports patients in rebuilding their relationships, by engaging in structured dialogues it provides the opportunity to explain how they would like to repair the damage, how they will make positive changes to their life and experience a process of reintegration. For the person harmed, they can have a say in how they want the harmer to make amends, the process may enable them to draw a closure to this experience (see Restorative Conferencing below, section 7.1).

## 7.1 Restorative Conferencing flow diagram:

## 7.2 PHASE 1: Case identification & Referral Process

7.2.1 **Case Identification:** Restorative Practice may be used where harm has been caused. The harm may take the form of physical and/or psychological harm. Physical harm would include pain, injury, illness or impairment caused by another. Psychological harm would include emotional or cognitive disturbances resulting from another's actions; it may manifest itself through worry (warranted or unwarranted), feeling upset or depressed, embarrassed, shameful or guilty, and/or result in the loss of self-confidence. The types of actions that may have taken place to cause psychological harm include; racist abuse, being humiliated, intimidated, shouted at, threatened, bullied or constantly criticised. Restorative Practice will supplement existing rehabilitation and recovery practices.

7.2.2 Eligible cases: Restorative Practice may be offered where patients have caused harm. There will be an identifiable victim who has suffered personal harm. The types of cases that may warrant a referral include;

- A conflict occurs between patient and patient; staff and patient.
- Staff and patients make complaints or have concerns about one another.
- Occurrence of physical aggression, verbal abuse, or sexual harm.
- Where psychological harm has resulted because of a patient's behaviour.
- A patient has caused harm to a member of the public.
- In relation to a patient's index offence.

7.2.3 **Please note: The current procedure does not provide processes to cover staff on staff conflicts. This will be added in a later revision of the procedure.**

7.2.4 Exclusion criteria

Cases not appropriate for Restorative Practice include;

- The harmer denies their crime and/or actions. The harmer blames the victim.
- The harmed or harmer choose not to participate; neither party must be forced, coerced, or bribed to take part.
- Where the motivation to engage is driven by a desire to humiliate, threaten, harm, or undermine the other party.
- Risk assessments unearth concerns regarding how the restorative conference will impact on the harmed, harmer, or other parties.
- Mental disorder is not a bar to participation, however, those suffering with psychopathy, severe anti-social personality disorders, unstable psychiatric disorders, or a severe risk of self-harm will not be suitable.
- The harmer and/or harmed do not have capacity.

7.2.5 **Referral Process:** Where harm has been caused a referral may be made to the Restorative Practice Team (RPT). A referral form must be completed and emailed to the restorative practice coordinators at the relevant site. The case may initially be discussed in the morning handover meeting at the low secure site or over email at the medium secure site and within the LDFOLS service. Two restorative practice facilitators will be allocated either at this time or when the team come together in supervision to discuss the case further. Acknowledgement of the referral will be made within five working days, initial contact with the harmed and harmer will be made within 10 working days. Both the harmer and harmed will be sent an accessible information sheet, informing them about Restorative Practices. The process thereafter will be determined by the needs of the harmed and harmer. The Restorative Practice facilitator should strive to be responsive to the needs of each and ensure momentum of the process is kept once initial contact is achieved.

7.2.6 Where the person harmed has chosen to inform the police, or the work is concerning a member of public, where appropriate KMPT will work in partnership with Kent Police in the implementation of the Restorative Practice intervention. If a safeguarding alert has been raised or the Police are investigating the incident because a crime has occurred, the facilitator is responsible for liaising

with these authorities to determine the appropriateness of commencing restorative work (See Appendix B). Where it is not appropriate to commence with a restorative intervention the facilitator will provide feedback to the referrer / harmer / person harmed, and will inform them what alternative support may be available to them.

7.2.7 Members of the RPT (Facilitators and Champions) will meet monthly to review referrals, allocate cases and discuss the process of cases.

7.2.8 Details of cases will be uploaded onto a restorative practice database, formatted in Excel. The database will comply with Trust policy and be listed with the Caldicott Office as an asset. The RPT will be responsible for the maintenance of the database. The database will be kept on the shared drive which only RPT members will have permission to access. As the database is an aggregate of all participants' data, it will be password protected.

7.2.9 The referrer will be kept informed, where appropriate, that action is being taken and will be provided with updates, where appropriate.

## 7.3 Confidentiality

7.3.1 Recorded information will provide data for evaluation, operational data for casework purposes, operational data for accountability and good management, data to identify best practice, learning opportunities, barriers and blocks (particularly in early stages of the initiative).

7.3.2 All data will be kept securely, please see below (sections 7.3.6 - 7.3.12) where information will be stored. A Restorative Practice file is available on the shared drive of the forensic low secure service and only those in the Restorative Practice Team are granted permission to access it.

7.3.3 All parties will be asked for their informed consent where information is wanted for research purposes. The BPS code of ethics will be followed in research activities.

7.3.4 Information concerning patients and staff will not be sent to third parties, unless the individual has consented, or there is an overriding public interest or justification for doing so. The Trust procedure on information governance and data protection will be followed.

7.3.5 Under the data protection act any information can be called for by HR or the staff member whom the information is about. Please refer to the NHS Code of Practice on records management for further detail regarding this.

7.3.6 Patient information: Contact with patients during the Restorative process will be recorded onto Rio, in the patient's progress notes. The nature of the conversation may mean it is not appropriate to document all details discussed (for example the patient is talking about the person they have harmed, and the person harmed is a member of staff who would have access to such notes). Where this is the case, bullet points outlining the contact will be recorded into Rio, however, more detailed notes will be saved onto the shared drive, in a file which only RPT members will have permission to access.

7.3.7 Closure reports concerning patients who have harmed, will be shared with the clinical team. Such information will contribute to risk assessment and management plans, and patient formulations. Patients will be informed of this at the start of the process.

7.3.8 Patient information will be stored indefinitely as per Trust policy.

7.3.9 Staff information: Contact with staff during the Restorative process will be recorded and saved onto the shared drive, in a file which only RPT members have permission to access.

7.3.10 Identifiable and sensitive information about staff who have been harmed will not be included in patient records (e.g. RP Closure reports).

7.3.11 Staff members' information would be held separate to patients' information and held until the RP process had been completed and for a further six months if there was no adverse outcome. Once completed the information could be securely destroyed.

7.3.12 If there was an adverse outcome such as criminal investigation these would have to be held in accordance with the retention schedules for NHS and the copies may become disclosable for that purpose.

## 7.4 PHASE 2: Risk Assessment

7.4.1 **Eligibility and suitability of the harmed and harmer:** The facilitator will meet independently with both the harmer and harmed. The assessment will be used to determine the suitability of a Restorative intervention and to decide what form of intervention may be possible, given the harm caused and the harmer's attitude to it. The purpose of the assessment is to assess the harmer's level of motivation, remorse, acceptance of responsibility and attitude towards the victim. The assessment will explore;

i. How much responsibility is being taken for the harm caused.
ii. The participant's motivation for a restorative meeting; what value do they see in the process and their willingness to engage respectfully.
iii. The risk of emotional and physical harm to participants and others and consider how risks should be managed (Patients risk assessments to be reviewed by the allocated facilitator).
iv. Any vulnerability issues that may impact on the participant's ability to engage.

7.4.2 Both parties must be willing participants and give informed written consent for a restorative conference to be convened. Consent to participate in research and evaluation purposes will also be sought for at this stage. Participants will not be excluded from the restorative process, if they do not consent to participate in research and evaluation.

7.4.3 The facilitator will ensure that by this stage both the harmer and harmed have received accessible information informing them about Restorative Practice. It may help to show each party a DVD such as the 'Woolf Within' to further help them understand about the process.

7.4.4 The facilitator will also ensure the harmed has been made aware of other support available to them;

i. Where the person harmed is a member of staff, KMPT staff support procedure, including the Low Secure Integrated Model of Staff Support procedure and TGU Critical Incident Stress Management Debrief procedure should be activated and procedures followed.
ii. Where the person harmed is a patient, the facilitator will ensure appropriate safeguarding alerts have been raised and other appropriate authorities informed where necessary (e.g. Kent Police). Such processes will take priority, ensuring any evidence needed for criminal proceedings does not become contaminated and it is safe to continue with a restorative intervention. A restorative intervention will be offered at a time the police / safeguarding officer have either concluded their investigations or have confirmed they agree for a restorative intervention to commence.
iii. Where the person harmed is a member of public, Victim Support Services, probation and/or Kent Police will be consulted with, determining their role in the proceedings and in supporting the person harmed.

7.4.5 Risk assessment will be undertaken throughout the restorative process, initially of the harmer and harmed and, if a restorative conference is planned, of all potential participants at the conference and the proposed venue. Risk assessment will need to remain central to the restorative process at all points throughout the intervention, whether the process leads to a letter of apology or to a conference. In the pre-conference phase the facilitator will look to assess;

i. The nature and level of risk of harm the harmer could pose to the harmed, staff and him/herself.
ii. The nature and level of risk of harm the harmed might pose to the harmer, his/her supporters and to staff.
iii. The nature and level of risk of harm the harmer and harmed supporters could pose by participating in a restorative conference.

7.4.6 HCR-20's/RSVP's/SAPROF's contain much qualitative information relevant to the planning and delivery of a restorative intervention, including a summary of criminogenic needs and risks, formulation, mental state, attitudes and risk to self as well as others. Facilitators will be required to familiarise themselves with the patient's risk assessment prior to offering this intervention.

7.4.7 Where the harmer is assessed as suitable, the harmed will then be assessed. If they agree to a restorative conference then the harmer and harmed supporters will need to be risk assessed as well as the conference venue. Conferences should take place away from the ward/location where the patient/staff member resides/works. For example, Broadview may be an appropriate meeting point where both the harmer and harmed are linked to the Low Secure Forensic Service (either patients or staff), and the Claremore Conference room may be appropriate where both the harmer and harmed are linked to the Medium Secure Forensic Service (either patients or staff). LD-FOLS will have their own procedures to risk assess venues (please see the LD-FOLS procedure, in preparation). Where the conference is to include members of the public a more neutral setting may need to be risk assessed.

7.4.8 Risk is a dynamic process and the facilitator will need to be alert to signs of possible re-victimisation during the process: e.g. changes in account of the offence, shift of blame to the harmed. Regular communication will need to be maintained with the patient's primary care team and any champions who may be allocated to support the harmer through the process.

## 7.5 PHASE 3: Preparation

7.5.1 **Planning for a Restorative Conference:** Preparation sessions will take place after the facilitator has met with the harmed and established what may be possible. During this phase the facilitator will support the participants to talk and think about the harm that has been caused. They will consider;
i. What they would like to get from the meeting.
ii. What they would like to say.
iii. How they might express their views.

7.5.2 The harmed will be supported to think about;
i. What happened. What was the hardest thing for them.
ii. How they and others were affected by what happened.
iii. What questions and concerns they are left with following the offence and its aftermath.
iv. Whether there are things that can be done, that would make things better.

7.5.3 The harmer will be supported to think about;
i. What happened and why.
ii. How they feel about it now.
iii. What they will do, to help make things better.

7.5.4 The length of time it takes to prepare for a conference will be determined by the needs of the participants. This work may be completed in one short meeting where the facilitator would outline

the process and ground rules. Alternatively, it may entail numerous meetings over several weeks, months, or years.

7.5.5 Diversity issues must be assessed and accounted for, these must be responded to by the facilitator and the restorative practice conference planned around such needs, maximising the likelihood of a successful outcome for both the harmed and harmer.

7.5.6 Each participant will be advised they may feel quite emotional after the conference and arrangements made for them each to have someone to talk to after the conference.

## 7.6 PHASE 4: Restorative Intervention

7.6.1 **Face to face Conference:** The Conference would be held in a neutral location which has been risk assessed. There would be a clear structure to the meeting, with agreed ground rules. The meeting would be used to identify what harm has been caused and would aim to develop a plan to repair the harm as far as possible, providing each party with an opportunity to have their say. At any time either party can change their mind if they decide they no longer want a restorative meeting.

7.6.2 The role of a facilitator is to adopt an empathic and non-judgemental position to ensure the harmed and harmer get the most from a face to face conference and that the dialogue is meaningful and restorative. The agenda would need to include;

i. Agreed ground rules
ii. Offender statement
iii. Victim statement
iv. Questions
v. Agreed action plan
vi. Closure

7.6.3 Ground rules would include, but are not limited to:

i. One person speaks at a time
ii. Use respectful language
iii. Do not interrupt others
iv. Everyone will be given an opportunity to speak
v. What is said in the room, stays in the room
vi. Space away from the conference may be taken where required

7.6.4 If wanted, both the harmer and harmed could have supporters in the conference supporting them. This would need to be agreed in the initial assessment and preparatory phase, enabling a risk assessment of the supporters to also be actioned.

7.6.5 **Alternative interventions:** It may not always be possible, or appropriate to conduct a face to face conference. Where this is the case alternative methods must be considered, these may include;

i. Shuffle conferences
ii. Exchange of letters
iii. Meeting without the person harmed; this may include having a victim-by-proxy, or a letter or statement read out on behalf of the victim
iv. Restorative conversations and less formal meetings (see restorative wards section above)

7.6.6 Where an alternative intervention is offered, it would still be essential to gather consents and complete the preparatory and risk assessment phases, ensuring the best possible outcome for both the harmer and harmed.

7.6.7 **Outcome agreement:** A successful restorative intervention will result in an agreed outcome. Agreements often incorporate actions that will further address the harm caused and will be decided and agreed upon by the harmed and harmer. Agreements might include, but are not limited to;

i. A letter of apology
ii. A safety plan
iii. Ground rules around the conduct of future relationships/interactions
iv. Ground rules around the disclosure of information
v. An agreement to undergo treatment

7.6.8 Every participant will be given a copy of the agreement to take away from the conference.

## 7.7 PHASE 5: Follow up and Closure

7.7.1 **Follow up:** Immediately after the conference, harmers should have someone available to them to talk with, rather than return to an empty room. They should be warned in the preparatory phase they may feel quite emotional after the conference. There could be a raised risk of self-harm and this will be assessed in the preparatory phase, with post-conference risk management procedures being agreed at that time.

7.7.2 Those that have been harmed will also be pre-warned of the potential for the emotional impact the conference may have and advised to make arrangements to have support available to them post conference. Facilitators will make themselves available to offer post-conference support to both participants in the following week.

7.7.3 Restorative Practice Champions should maintain regular contact with participants of restorative practice and inform facilitators if they notice any signs of distress. Where concerns are noted Champions will report these to the patient's clinical team, initiating the need for an assessment of their mental and emotional state.

7.7.4 **Outcome agreement implementation & monitoring:** Every participant will be given a copy of the outcome agreement to take away from the conference. Appropriate and relevant individuals will be identified in providing a key role in supporting the harmer to act on the agreement; they will meet with them regularly maintaining momentum of the intervention and encouraging the harmer to regard the intervention as a process rather than an isolated, albeit meaningful, event. The facilitator will arrange a time to meet with the harmer to review how they have complied with the agreement.

7.7.5 The Restorative Practice facilitator will meet with the harmed to inform them of the harmer's progress, even where they have failed to meet obligations. If an agreement includes completion of a treatment programme, it may be appropriate to inform the harmed that the harmer has commenced the programme with good engagement; however, regular updates regarding their path to recovery would not be appropriate.

7.7.6 **Closure:** Participant Satisfaction - User feedback will be an essential element to ensure the best outcomes of the Restorative Practice process are achieved for those who have been harmed and the harmers. Participants will be asked to complete a feedback form, regardless of what stage they reached in the restorative process and regardless of the type of intervention. Such information will be used to enhance and develop the practice of Restorative Practice across the service. Someone neutral to the intervention will be asked to support participants in completing the satisfaction form.

7.7.8 Closure Report: The allocated facilitator will compile a closure report, outlining;

- The nature and the impact of the harm caused
- The restorative practice intervention utilised
- The engagement and attitudes held by the harmer
- Agreed Outcomes and how these were met by the harmer

7.7.9 The report will be sent to the patient's clinical team allowing integration with their risk assessment and risk management plans and formulation.

7.7.10 Data recording: The allocated facilitator will input case details into the restorative practice database. This will be vital for the ongoing assessment and monitoring of the intervention.

7.8 **Supporting Documentation:** A facilitator pack is available on the shared drive and is available to all restorative practice facilitators. The pack is designed to support facilitators through the restorative process, providing all necessary information for both them and the participants. The pack includes;

- Information sheets listing key points to cover in the initial preparation session with both the harmer and harmed.
- Consent forms for the harmer and harmed.
- Risk assessments for the harmer, harmed and supporters.
- Progress sheet to record discussions with staff and patients, including information on where and how to store both staff and patient notes.
- Venue risk assessment
- Seating arrangements plan
- Script for the conference
- Outcome agreement
- Closure report
- Satisfaction Questionnaire

## 8 COMPLIMENTS AND COMPLAINTS PROCEDURE:

8.1 Participants of Restorative interventions will be provided with Trust leaflets on the compliments and complaints procedure when requested.

## EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 places a statutory duty on public bodies to have *due regard in the* exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

## HUMAN RIGHTS

The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

## MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

Try to use the following table to show how implementation of the procedure/ guideline/ protocol will be monitored

This section may also include details of review – although not necessary to repeat a date if that is on the front page

Remember – if a process is documented it must also include how it will be monitored

| What will be monitored | How will it be monitored | Who will monitor | Frequency | evidence to demonstrate monitoring | Action to be taken in event of non compliance |
|---|---|---|---|---|---|
| Numbers & nature of restorative interventions; staff involved, satisfaction ratings and outcomes. | Database stored on a shared drive. | Sarah Cooper | Annually | Annual reports | Review of systems in place. Meetings with professionals involved and line management. |
| Evaluation of restorative wards. | QIP projects | Sarah Cooper | As required | Reports following first year of implementation | Meetings with professionals involved & line management. |

## APPENDIX A EQUALITY ASSESSMENT SCREENING

| **General Information** | |
|---|---|
| Name/s of function:<br>(*State whether service, policy, project etc)* | Procedure |
| Directorate: | Forensic and Specialist Care Group |
| Function Owner: | Sarah Cooper |
| Date of screening: | 14.07.2023 |
| Is this a proposed, new or existing function? | EXISTING |

**Aims of function and monitoring arrangements**

Restorative practice is a process in which victims (a person harmed) and perpetrators (the harmers) come together in a controlled environment, to communicate about a wrong doing. In a face to face meeting they are supported by a trained facilitator to talk about the harm that has been caused and find a way to repair that harm. Restorative Justice aims to allow each person to process and share how they are feeling through helpful communication, relationship building, and communication of moral values.

Restorative justice has been found to benefit both the harmed and harmers. For the harmed the process has been shown to;

1. Offer a process in which they can reach a sense of closure and reassert some control over their situation.
2. It allows them to tell the harmer the real impact of their act, get answers to their questions and also get an apology.
3. The process has also been found to empower the harmed by giving them a voice.

With regard to the harmers the process has been shown to;

1. Give them the chance to reflect more on the impact of their behaviour.
2. Offer them an opportunity to think about and relearn how they might behave in the future.
3. It also holds them to account for what they have done and helps them to take responsibility and make amends.

The aim of a restorative ward is to create an environment which fosters awareness, empathy and responsibility, where informal restorative practices become a part of everyday life. Outcomes of an initial pilot demonstrated improvements approaching statistical significance in measures of therapeutic hold, patient cohesion, and experienced safety, as well a reduction in harms experienced on the unit.

Do you monitor the policy, procedure or practice in relation to any of the following?

☒ Complaints ☐ Eligibility criteria ☐ KPI's ☐ Service Uptake

☒ User Satisfaction ☐ Equality characteristics ☒ Other: Research & Audit

Which protected groups of people will be affected by the policy, procedure or practice? E.g. particular service users, staff, patients etc. Please tick the box if any of the following protected groups will be affected? Provide brief details about the nature of impact. Use, anecdotal qualitative or quantitative in-house information identified above both local and any regional and national research findings, surveys, reports, research interviews, minutes from focus groups, anecdotal evidence stated in organisational documents, other forms of engagement activities, pilot activity evaluations etc. If there are gaps in evidence state what you will do to close them.

| | |
|---|---|
| Age YES ☐ NO ☒<br><br>Detail nature of impact | Disability YES ☐ NO ☒<br><br>Detail nature of impact |
| Gender reassignment YES ☐ NO ☒<br><br>Detail nature of impact | Marriage and civil partnership<br>YES ☐ NO ☒<br><br>Detail nature of impact |
| Pregnancy and maternity YES ☐ NO ☒<br><br>Detail nature of impact | Race YES ☐ NO ☒<br><br>Detail nature of impact |
| Religion and belief YES ☐ NO ☒<br><br>Detail nature of impact | Sex YES ☐ NO ☒<br><br>Detail nature of impact |
| Sexual orientation YES ☐ NO ☒<br><br>Detail nature of impact | Other<br><br>Detail nature of impact |

**DETERMINING EQUALITY RELEVANCE OF THIS FUNCTION?**

Does this function have Relevance to Equality & Human Rights?

YES ☐ NO ☒

*Note: Public authorities need to consider all of their functions in order to determine which of them are relevant to the aims of the duty. Some functions will be relevant to most or all protected groups.*

PROPORTIONALITY - Based on the answers above what weighting would you ascribe to this function? LOW

| HIGH | MEDIUM | LOW |
|---|---|---|
| High relevance to equality, /likely to have adverse impact on protected groups | Medium relevance or Insufficient information/evidence to make a Judgement. | Low relevance or Insufficient information/evidence to make a judgement. |

State rating & reasons:
*(Green or Low equality relevance of function means does not have to undergo full impact assessment because it has nothing to do with protected groups).* Function owner should conclude the process at this stage.

If you ascribed function equality & human rights proportionality as Red or Amber – Please provide reasons.

Is a Full Equality Impact Assessment required?

YES ☐ NO ☒

*(If no, please DO NOT CONTINUE Just date and sign at the end of the form).*

| | |
|---|---|
| YES - If you have established that there may be some equality relevance adverse then proceed to the Full Equality Impact Assessment | |
| Additional comments: | |
| Date Screening was completed | 14.07.23 |
| Screening Lead: | Signed:<br>Date: 14.07.23 |
| Head of Department/Directorate: | Signed: Date |

**(This should show the Screening done by the Policy Owner prior to this stage)**

**If it is felt the policy requires a full equality impact assessment this form can be found by clicking on the below link**
http://staffzone.kmpt.nhs.uk/Downloads/staffzone/policies/EqIA%20Full%20Assesment.doc

## APPENDIX B REFERRAL PROCESS