All Party Parliamentary Group on
appg | Restorative Justice

# APPG Investigation:
# Implementing restorative practices in education, health and social care

## Advisory Board Investigation Report

## 1 Forward by the Advisory Board Chairman

This investigation focused on the current implementation and impact of restorative practice in non-judicial settings across the UK. Our findings, and subsequent recommendations, are based on the reported experience of restorative practitioners working within education, health and social care settings who embraced the opportunity to contribute evidence to demonstrate their successes whilst highlighting where improvements could be made.
During the investigation, we heard compelling evidence demonstrating the positive impact restorative practice can have in transforming the way in which organisations relate to those accessing their services, support better relationships between service users, and improve internal relationships between professionals. This was particularly evident within the testimony of those working within health services with the implementation of the 'Just Culture' model. We also heard that applying restorative practice principles within social care offered an alternative to professional and process-centred approaches.

Whilst exploring the way in which restorative practice is being implemented in each of the three areas, we learnt that there are common obstacles which hinder wider implementation. This included gaining senior leadership buy-in, a lack of dedicated funding and an absence of a cohesive government strategy to bring together the siloed restorative work being undertaken.

This investigation report identifies many positive examples of how restorative practice is being used. However, as outlined within our report, there is still much that needs to be done to encourage greater use and improve the quality of restorative practice implementation across Education, Health and Social Care settings.

The Advisory Board is committed to supporting the APPG to call on the Government to use this report to help inform future public policy and invest in a co-designed review of the relational aspects of current Education, Health and Social Care systems to inform the development of a cohesive government strategy for the longer-term implementation of restorative practice.

I would like to thank all those who gave evidence to the investigation and of course my co-chair, Dr Terence Bevington, for his support in delivering this investigation and our fellow- Advisory Board members for their thoughtful contributions.

Jim Simon
Restorative Justice Council,
Chief Executive Officer
Chair of the APPG Advisory Board

Jim Simon

# 2 Introduction to the investigation

The Restorative Justice All-Party Parliamentary Group was established on the 21st April 2021 by Elliot Colburn MP, along with Fiona Bruce MP, Crispin Blunt MP, Neale Hanvey MP, Tony Lloyd MP, Christina Rees MP, Baroness Molly Meacher, and Baroness Sally Hamwee. At this meeting CalComms were appointed Secretariat of the APPG.

The mission statement of the APPG is:

**To examine the use of restorative justice principles within the UK justice system and beyond; to raise the profile of restorative justice principles within Parliament; and to provide opportunities for policy discussion and consultation.**

Following the publication of the APPG's Restorative Justice Inquiry Report in September 2021, members of the APPG sought to further investigate the broader use of restorative practices across the UK. The primary focus of this investigation was to identify the current use, benefits and/or use of to using restorative practices in education, health and social care settings. The investigation comprised of three parts:

- Written evidence, from organisations and individuals with expertise in Restorative Practice.
- Oral evidence, taken at oral evidence sessions.
- This report, based on the evidence collected.

The investigation examined three key themes: implementation, impact, and benefits.

The APPG received evidence across a wide range of sector leaders, practitioners, advocacy groups and academics. This report provides a summary of these responses, weighted based on the volume of evidence provided to the investigation. It is not a full account of all the evidence given to the Inquiry, but a summary of key points that provides an evidence base for the 7 key recommendations at the end of this report.

# 3 Executive Summary

This report sets out some of the current uses of restorative practices within education, health and social care settings across England and Wales. In its recommendations, it identifies 7 key suggestions for what more can be done to disseminate the benefits that quality restorative practice can bring to individuals, communities and organisations. Prepared by the All-Party Parliamentary Group (APPG) for Restorative Justice, this report is based on written evidence received from 51 practitioners, national organisations and academics, 3 Advisory Board Roundtables and from 3 APPG oral evidence sessions with key stakeholders from across the education, health and social care sectors.

Across the three sectors of education, health and social care, some common themes emerged. In all three sectors, restorative practice presents and represents an alternative to the status quo: in schools, an alternative to behaviourist, punitive approaches; in health, an alternative to disciplinary responses to harms that occur within the workforce, and to the litigation culture; and in social care, an alternative to professional and process-centred approaches. In all three sectors, it is recognised that embedding a restorative culture takes time and requires informed long-term commitment by leaders. In order to build capacity within the systems and thereby become sustained, implementation needs to go beyond a mere train-and-hope approach and be more evidence-based and strategic. The common benefit of adopting a more restorative approach in these human-centred sectors is that it places people at the centre of processes.

## Education

Restorative practice in education has enormous potential to transform relationships, reducing incidents of harm, improving achievement and creating healthy, happy school and college communities. By giving students and staff the skills to resolve conflicts before they escalate, exclusions are reduced or stopped altogether and staff wellbeing improves

In explaining their reasons for implementing a restorative approach (RA) in schools and other education settings, respondents referred frequently to the limitations and indeed the negative impacts of punitive approaches to managing behaviour and relationships. Respondents cited a desire to adopt an approach that prioritises social learning and stronger relationships, rather than one that seeks passive social conditioning through practices and systems of control and compliance. Compelling evidence was provided by MIND and the Commission on Young Lives, established in 2021 as an independent commission to develop proposals for a new national system to prevent crisis in vulnerable young people, on the dangerous impacts of punitive approaches to discipline and exclusion on young people's mental health and life chances.

Implementation can focus too much on the delivery of training, often lacking a more strategic implementation plan. There are some examples of more strategic implementation at individual school and Local Authority levels. A range of practices have been identified as being used in schools and other education settings. These practices are applied between adults, between adults and students, between students and students, and with families. The practices apply to repairing harms, building community, developing voice and creating a context for learning.

At school-level, the impacts reported can be categorised into student, staff and whole school impacts. Working restoratively helps students develop key lifeskills in the domains of communication, social and emotional capabilities, relationships, and conflict management. Staff are reported to become more competent and confident in working with students and behaviours, developing a better understanding of their students and also of the behaviours that present leading to reduced labelling of 'problem' students, and an increased empathy towards them. Many respondents identified staff reporting an enhanced and enriched sense of connection with their work with resulting reductions in staff absence, particularly for work-related stress, as well as increased

staff retention. At a whole school level, adopting a restorative approach has resulted in calmer, more reflective, more caring and more responsible school cultures, where there are stronger relationships at all levels and a stronger sense of the school as a community. There is an improved climate for learning with improved behaviour for learning. Exclusions are reduced and attendance is increased.
The obstacles identified by respondents can be classified as either philosophical or practical. The philosophical obstacles refer to people not 'buying into' the approach, often expressing a belief that a punitive approach is preferable. Some of the practical obstacles include resources such as time and finances. Other practical obstacles include staff turnover and innovation-overload that can make it difficult to sustain RA as a school priority.

## Health

Restorative practice has been found to be of significant value in a range of settings, and the investigation learnt about some innovative projects applying restorative practice to health settings. This is very early days but clearly the potential benefits could be considerable. The evidence suggested that restorative practice is becoming more commonly used across the health sector however, it is apparent that the way in which restorative justice and practices are being implemented does vary depending on the setting and individual trust's and/or services interpretation of what this looks like in practice. This lack of clarity appeared to stem from an absence of any established body of practice deemed to be restorative, such as exists in other sectors.

The most established use of restorative practice was seen within NHS Forensic Mental Health Services. Respondents told us they typically use restorative justice in relation to incidents involving patients and/or patients and staff. However, in some instances these services also work in collaboration with an external restorative provider to progress restorative cases with victims of crime.

Across the wider health sector, restorative practice tended to be isolated projects focusing on specific areas of health care for example, the Resolve Partnership Programme implemented at University College London Hospitals NHS Foundation Trust who run a pilot project to explore restorative responses to adverse events specifically, incidents arising from NHS birth reflection clinics that highlighted patient concerns with their care. An exception to this is the introduction of a Restorative Just and Learning Culture (RJ&LC) by Mersey Care NHS Foundation Trust, an area of practice which is explored in greater detail in the summary below.

Evidence was also heard from patients and groups representing them including the Harmed Patients Alliance, a patient advocacy group specifically supporting adoption of restorative principles and practices in the design and delivery of responses to individuals and families who have been harmed because of the care they have received. This evidence presented an additional dynamic, notably the impact that existing restorative practices have on patients, their families and/or carers who have suffered harm.

It is important to recognise that at an early stage of the investigation, it became apparent that the restorative language used was considered important and getting this wrong could be problematic. The term 'restorative justice' was explicitly rejected by most participants, as it was considered too closely aligned with the criminal justice system. However, patient advocacy groups mostly disagreed stating that in their opinion, restorative justice means focuses on the 'just' response to the harms suffered and enabling 'just' relations going forward. This issue surrounding language is not unique to the health sector, indeed it was replicated across the education and social care sectors.

## Social Care

Restorative practice within social care is a new and emerging sector, with high stakes and considerable social and financial benefits. The ways in which restorative practices are currently being used in social care are varied; some new, such as contextual safeguarding conferences and some which have been going a long time like Family Group Conferences, a professionally supported problem solving and decision-making meeting involving the child's wider family network which aims to plan the support the care, protection and wellbeing of the child.

Although restorative practice is being more widely applied in social care settings, there is a need for greater clarity about what practice should look like. Without this, there is a risk that 'restorative' just becomes a buzz word for anything that is positive and a greater risk that it becomes so watered down it is meaningless.'

Evidence suggested that the most successful implementation requires top-down leadership with vision rather than individual staff or departments implementing restorative ways of working in isolation. Senior leaders must lead by example and secure support from dedicated project leaders to drive implementation and embedding of the approach.

When fully embedded, restorative practice is transformative. Restorative practice has the potential to influence a change in culture and practice in Children's social care and more widely to one that consistently works with children and families, places emphasis on building and maintaining positive relationships, and sees that family networks themselves are a valuable resource in helping children remain safely at home and avoiding a need for them to enter the care system.

# 4 Summary of Findings

## A) Education

A wide range of both written and oral evidence was provided during this investigation specifically focusing on the implementation of restorative practices across the education sector. This included the views of those working within primary, secondary and special schools, Universities, Local Authorities, Multi-Agency Trusts, independent consultants, and charities. The data confirm and, in many cases, extend and refine what is known from the international evaluation literature.[1]

### Rationale for adopting a restorative practices

In explaining their reasons for implementing restorative practice (RP) in schools and other education settings, respondents referred frequently to the limitations and indeed the negative impacts of punitive approaches to managing behaviour and relationships. Respondents cited a desire to adopt an approach that prioritises social learning and stronger relationships, rather than one that seeks passive social conditioning through practices and systems of control and compliance. Compelling evidence was provided by MIND and the Commission Young Lives on the dangerous impacts of respectively punitive approaches to discipline and exclusion on young people's mental health and life chances.

### Implementation

The most frequently mentioned element regarding the implementation of RP in schools is training for all staff across the school. In some cases, little mention is made of a more strategic model of implementation, confirming the risk identified in the international evaluation evidence of the predominance of a 'train-and-hope' model; that is invest in training and hope that it encourages the implementation of RP across a school.

There were several examples of a more strategic approach to implementation, including one respondent's articulation of a three-fold model that includes conceptual, pedagogical, and routine restorative practice.[2]

At the broader Local Authority or Multi-agency Trust levels, there were further examples of strategic implementation, which included leadership programmes for headteachers and senior leaders, incorporating RP into school development and improvement plans, connecting restorative work with other school focuses, and developing relationship policies rather than behaviour policies.

The restorative practices that are typically seen in schools range from the individual, through the interpersonal to the group levels, and from the informal to the formal. Named practices include individual restorative thinking and reflection, the use of affective statements, adults modelling behaviours and language, and one-to-one restorative conversations. In some settings, students are trained to engage their peers in conflict coaching or peer mediation to help them resolve their conflicts more constructively whilst trained adults facilitate restorative meetings, more formal restorative conferences, as well as group work influenced by restorative language and processes. In some settings, internal Human Recourse (HR) processes have been adapted to include restorative practices. A wide range of proactive and responsive circle techniques are used for example, check-ins, check-ups and check-outs, community-building circles, peace-making circles, learning circles (used to co-create approaches to learning and assessment), solution-focused circles and wellbeing circles. These diverse practices are applied between adults, between adults and students, between students and students, and with families. The practices apply to repairing harms, building community, developing voice and creating a context for learning.

A number of aligned and complementary approaches were named by respondents as being reciprocally supportive of RA. These include Zones of Regulation, Emotion Coaching, Trauma-Informed practices, and Shame-Sensitive practices. Other potentially contradictory approaches such as Positive Discipline were identified by some respondents as having the potential to be merged with a restorative approach by engaging students in dialogue about how they affect the relationship climate thus learning social responsibility. Several respondents made explicit mention of the reparation element of a restorative approach, including examples of how to offer opportunities for students to make practical amends to the school community when harm or damage is caused.

### Impact

Impact of adopting a restorative approach is measured and evaluated in a range of ways, gathering both quantitative and qualitative evidence. The methods applied include surveys, interviews, case studies, and school data (e.g. behaviour referrals, attendance, suspensions and exclusions). In addition, there are some examples of collaboration with universities to generate more academic evaluations of school-level and Local Authority level practices.

At school-level, the impacts reported can be categorised into student, staff and whole school impacts:

*Students*

The benefits reported for students cover both the development of capabilities that enable them to engage more securely and competently in all areas of school life, as well as the development of key life skills. Working restoratively helps students develop key life skills in the domains of communication, social and emotional capabilities, relationships, and conflict management.

Students' expressive and receptive communication skills are improved through learning to listen to one another with more attention, improved emotional language development, even with very young children (3–4-year-olds), and improved oracy. Students' social and emotional development is enhanced through working restoratively, with reported improvements in students' capacity for reflection and self-regulation resulting in reductions in behaviour incidents.

Relationships between students and staff are strengthened as students become more trusting that the adults will help them sort problems out rather than punish them. This increased trust leads to students being more honest and taking responsibility for their actions The increased trust also leads to more students feeling safe to disclose their concerns, worries and needs to staff.

With regard to their conflict competencies, working restoratively helps students to be honest, take responsibility for their actions and for putting things right, thus developing their ethical literacy. Students learn to resolve their disagreements with one another, and also to help their peers resolve their difficulties, thus reducing the need for adult intervention.

*Staff*

There are a range of impacts on staff reported by respondents, which are supported by the research-based evidence. On one level, staff become more competent and confident in working with students and behaviours. Through working restoratively, staff develop a better understanding of their students and also of the behaviours that present, recognising that challenging behaviour is a child's way of communicating what is going on for them. This leads to a reduced labelling of 'problem' students, and an increased empathy towards them. Many respondents identified staff reporting an enhanced and enriched sense of connection with their work with resulting reductions in staff absence, particularly for work-related stress, as well as increased staff retention.

*School*

At a whole school level, adopting a restorative approach has resulted in calmer, more reflective, more caring and more responsible school cultures, where there are stronger relationships at all levels and a greater sense of the school as a community. There is an improved climate for learning with improved behaviour for learning. Exclusions are reduced and attendance is increased. Whilst we were unable to corroborate a direct link to the reduction of violence towards staff, our evidence did suggest there is an overall improvement in relationships and a decrease in violent incidents.

**Obstacles**

The obstacles identified by respondents can be classified as either philosophical or practical. The philosophical obstacles refer to people not 'buying into' the approach, often challenging with beliefs that a punitive approach is preferable. Buy-in can be an obstacle with school leaders, school staff, and with parents. An aspect of this difficulty lies in an insufficiently informed understanding of what RA is. It might be considered a soft option, when people do not have a full understanding of the accountability and reparation element of the approach. Alternatively, RA can be misappropriated and applied disingenuously as a sanction. Some of the messaging about behaviour in schools nationally from the DfE and Ofsted are felt to be in contradiction to or confused about restorative practice.

Some of the practical obstacles include resources such as time, both in terms of engagement in a dialogic approach to dealing with conflict taking more time in the day-to-day, and also in terms of it taking some years to embed culture change. Limited school budgets and financial resources are also cited as obstacles. Staff turnover, especially at leadership level can derail a school's restorative journey. Innovation-overload can be an obstacle to sustaining implementation, given the continuous influx of new initiatives within education and the resultant difficulty in sustaining RA as a school priority.

## B) Health

A wide range of both written and oral evidence was provided during this investigation specifically focusing on the implementation of restorative practices across the health sector. This included the views of those working within NHS Trusts, Secure Forensic Mental Health settings and patient advocacy groups.

**Rationale for adopting a restorative practices**

Participants told us there are many reasons for health organisations to consider the application of restorative practices. For some, it was the desire to create a restorative organisation, from top to bottom, viewing the organisation itself as a community but by far, the most significant use of restorative practice shared with this investigation was to tackle formal disciplinary issues and specific issues such as violence towards staff.

The use of restorative practices to address the growing level incidents of violence in health settings was felt to be important. Those giving evidence highlighted that existing procedures for reporting such incidents are ineffective and too frequently, the police take 'no further action' asserting that pursuing a conviction would not be in the public interest.

Increasingly, restorative practice is being used across the National Health Service to support organisational learning following incidents of harm caused to patients when medical procedures or treatment go wrong. This was most evident in the widespread implementation of a 'Just Culture' across many health care organisations and Trusts.

Professor Sir Norman Williams's Review (2018) into Gross Negligence Manslaughter in Healthcare stated, 'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'.

Sir Norman goes on to say "…generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts."

Evidence provided by Mersey Care NHS Foundation Trust demonstrated how a "Just Culture" has been embedded within their trust. Simply put, when something goes wrong, they now ask about who was affected, what their needs are and determine whose obligation it is to meet them. They recognised that older models of practice, with those demands for a more retributive approach, are a blunt instrument, an expression of power over justice which hinder the acceleration of any learning or improvement.

There was an overwhelming sense from those presenting evidence that existing policies and procedures, particularly formal disciplinary and complaints processes, impact negatively on staff and patients which ultimately hinders organisational learning in the longer term. Organisations moving towards creating a "Just Culture" was widely accepted as being positive for staff and patients. A concern raised about 'Just Culture' by patients was that it is getting a reputation amongst the harmed patient community as being 'one sided', concerned with psychological safety and meeting staff needs after harm, and not about the justice and healing needs of patients and families. This could be experienced as further injustice.

Evidence provided by one patient advocacy group suggested the adoption of a "Restorative Just Culture" that is inward facing and not inclusive of the needs of patients and families could risk creating inequity. For example, between emotional and psychological support on offer to staff involved in incidents (peer and psychological support, timely, and provided by or funded by their employer) vs patients and families (no peer support, and often signposting, with lengthy waiting lists, or self-funded support from private providers).

It was also suggested that there is a danger of organisations prioritising their own needs after harm events (organisational learning) and limiting obligations towards patients' families and staff to what support they need to be open with, engage in, and avoid compounded harm from processes aimed at organisational learning. This fails to proactively seek to attend to the justice and healing needs these groups may have outside of the scope of the learning review. This is reflected within the national guidance for engaging and involving patients' families and health staff in learning reviews following a patient safety incident which states it does not cover 'restorative healing', described as, 'a specific method that must be carefully facilitated by trained individuals.' (There is no national guidance for trusts that recommends use of such a method to address patient family and staff needs that fall outside the scope of the learning review).

Another context in the health sector where restorative practice has been adopted is Secure Forensic Mental Health settings. Managed by the NHS, these settings provide specialist services for people who have a mental

health problem and have been arrested, are on remand or have been to court and found guilty of a crime. As such, many patients are subject to special controls by the Justice Secretary due to the level of risk they pose. Within this report, we have only focused on how restorative practice is being used internally although recognise that many of these services have well established restorative programmes supported by external services to repair the harm caused to victims of crime.

Evidence demonstrated that the implementation of restorative practice within Secure Forensic Mental Health settings is more evolved, despite there being no formal mandate as to how restorative practices should be used, there is a more defined understanding of the rationale for implementing restorative practices. Participants accepted there is scepticism as to how restorative practice could be used and recognised that it could be perceived that those with certain mental health diagnosis could potentially be considered unsuitable to participate in any form of restorative process. However, the evidence provided demonstrated that risk assessment processes have been developed which consider a patient's ability to take responsibility and/or consent to participation, their level of interpersonal skills, and capacity for empathy.

We were told while some patients within Secure Forensic Mental Health settings have access to well-resourced services however, the needs of those who have been harmed by a patient's actions are less resourced and often only attended to in a small way. Participants told us that the use of restorative practice initially focused on institutional violence between patients, and patients and staff. This has, over time, developed to focus on the harm caused by indifferent interpersonal difficulty, bullying, harassment and as part of other internal processes such as seclusion reviews following periods of isolated involuntary confinement. One participant from a medium secure setting explained that restorative practices have been extended to the work being undertaken with family and carers who have a relative in hospital by providing opportunities to repair damaged family relationships. Participants were clear that their current practice only reflects a fraction of what is possible; many are now starting to explore how restorative practices can be used to resolve other difficulties in the workforce.

**Impact**

Measuring impact was challenging as none of the health organisations providing evidence had adopted a formal system for recording restorative practice. Participants put forward a persuasive argument that it was better to measure impact on existing performance measures rather than developing new ones. However, it was also felt there was a risk that the connection between

the restorative intervention and a positive outcome might not be made strongly enough against existing key performance indicators to justify continuing and greater investment in restorative practice. There was also concern that by developing specific performance measures for restorative practice, Trusts could be subjected to undue pressure being applied to deliver restorative practices which could result in unsuitable cases being selected to meet performance targets.

Where restorative practice is being used with staff as part of human resources, there are a range of key performance indicators against which impact can be monitored. This included gathering and analysing data on levels of absenteeism, sickness and the number of formal disciplinary proceedings being undertaken.

In addition to the indicators above, those organisations implementing a 'Just Culture', were also able to measure impact against patient key performance indicators including improved learning when things go wrong and better engagement with families. We were told during the oral evidence session that a restorative just culture is fair to staff regarding their role in the harm event and understanding the causes of the incident. It moves away from blame and scapegoating and encourages collective responsibility. However, from a patient's perspective, often the first opportunity to talk about the collective responsibility for the harm they came to as a result of the incident, and obligations for meeting the needs created by that harm is with a lawyer. Patient representatives felt that the current 'Just Culture' framework did not sufficiently seek to address what is 'just' for patients and families harmed by safety incidents.

Within Secure Mental Health settings, the impact of restorative practice was often measured in relation to better health outcomes for patients specifically, measuring the reduction in the need for need for out of area placements because patient on staff violence is better managed and prevented. One participant explained that conflict between patients or patients and staff can have a detrimental impact on the quality care and/or access to appropriate health interventions. For example, if two patients both need to attend the same therapy group and are separated because of safeguarding requirements following a conflict, they can't access the treatment that they need together which ultimately impedes their progress.

Likewise, this also applies to some extent to non-forensic settings particularly where a member of staff has been assaulted which could lead to a patient not being readmitted locally in the future and therefore required to access costly out of area placements. Some Forensic Mental Health services are starting to collect more specific data on the level of restorative

activity being undertaken, the number of referrals being made to specialist third sector restorative justice services and the number of staff wanting to become trained restorative facilitators. Participants felt it would be positive for health services to be measured on their restorative offer to patients. However, we were also told that the Care Quality Commission, as the lead inspectorate for the health sector, appear to have limited interest in restorative practices.

**Obstacles**

It would be remiss not to recognise the impact the Covid pandemic had on the restorative work being undertaken across our health services. During this time, extreme pressures were placed on the National Health Service and priorities had to change. For many, this resulted in limited or no restorative work being undertaken over the past two years. It is also important to recognise that health services are still recovering.

Despite this, the evidence suggested that there is a general lack of awareness and understanding of restorative practice across the health sector. Participants told us that with a plethora of health service initiatives there is a significant risk that restorative practice is considered yet another 'trendy initiative'. Where health services are using restorative

practice, it often relied on one dedicated leader being the driving force. This becomes problematic when the individual moves on.

Participants told us that without senior 'buy-in', systematic and sustained change is unachievable. There was a consensus that there is often a disconnect between leaders and front-line staff and the former are often far removed from practice on the ground. Some participants told us that a source of frustration was that health leaders do not make the connection between working more restoratively and the potential financial savings relating to reduced absenteeism, sickness, tribunals and litigation.

It is also important to recognise that most health services do not receive dedicated funding to implement restorative practices, and that this must be funded within existing, already stretched, resources. Participants told us that a primary focus has been on developing the skills of the current workforce with an emphasis on training. Whilst this approach is positive, there are concerns that staff do not have the capacity to undertake more formal restorative processes. One Secure Forensic Mental Health Service has created a full-time restorative practitioner role, the first of its kind in the UK. This has had a positive impact on their service and has the potential to be rolled out across other NHS trusts.

Changing mindsets was considered a significant obstacle. Participants told us the attitudes, policies and practices of professional bodies, alongside a legacy of a risk averse and blame focused culture, continue to present obstacles to working more restoratively across the health sector. Those working in the health sector felt that there is an embedded expectation that when things go wrong, someone must be at fault and, in some way punished. Whilst it was acknowledged that the introduction of a 'Just Culture' has started to shift this thinking, there is still a disconnect with the expectations held by professional bodies such as the General Medical Council whose processes focus on proving negligence and holding individual health professionals to account. Participants recognised that this is important but felt the process could be more restorative and closer aligned with a 'Just Culture.'

Those advocating for patients felt strongly that existing systems can still leave harmed patients and families feeling like they are perceived as a risk to be managed rather than suffering people to be cared for. For many patients, this is experienced as health organisations prioritising a perceived threat to their reputation and/or potential financial damages over the risk of further harm to the patient, family, and frontline staff involved. The Harmed Patients Alliance told us that this often leads to patients and families being forced into trying to achieve a sense of justice via adversarial processes that frequently cause avoidable psychological harm to them and staff, as well as having the potential for greater reputational damage and higher financial costs to health services.

Those providing evidence recognised that more needs to be done to build patient trust following incidents of harm. It was accepted that for many patients, there is a belief that when things go wrong it will be covered up. The introduction of a 'Just Culture' does provide a restorative framework to support staff and clearly focuses on future organisational learning however, patient advocates felt this falls short of what is needed to rebuild trust and repair relationships after harm. A more restorative response which would be to willingly take responsibility for harms caused by the incident and proactively explore with the patient appropriate obligations in relation to meaningfully meeting the healing and justice needs the harm has created. For this to happen, significant changes are needed to government policy, organisational mindset and the current culture of litigation and risk management.

## C) Social Care

Written and oral evidence on implementing restorative practices in both the children's and adult social care sector was provided during this inquiry from 9 local authorities, academics, the Restorative Justice sector and others.

**Rationale for adopting a restorative practices**

As with other sectors, evidence suggests that successful implementation requires leaders with vision who set the tone and lead by example so that restorative practice cascades throughout the organisation. Organisations also benefit from dedicated project leaders to drive implementation and embed the approach. Participants told us that restorative practice in social care can be seen as both a practice model and an ethos. As an ethos it aligns with social work values and principles, and as practice it complements other strength based and relational approaches.

**"The introduction of restorative practice is part of a bigger culture change. It becomes part of who we are."**

It was widely accepted that restorative practice is about giving people a voice. For social care staff, it builds confidence and provides a structure for having a different conversation. Participants told us that restorative practice has the potential to move away from the blame and shame culture, which can be quite prevalent within social care, to a more positive and transparent culture with promotes healthy relationships and open and honest conversations with children and families.

We recognise that restorative justice is typically considered to focus on repairing harm after it has been caused. However, within social care, being restorative is also focused on developing good relationships, having caring conversations, properly listening and empowering children and families to make decisions with a social worker. Participants told us that this type of approach is more likely to lead to families making positive changes and less likely to feel that decisions, and subsequent actions, are done to them.

Participants were acutely aware that in social care, there is a unique relationship in terms of to power, and the power that the social workers have with the family. This presents a challenge to the social worker role given there is an inherent tension between showing care and potentially having to remove children. Whilst we need to acknowledge the complexities of power within social work relationships, it was accepted that restorative practice does address power dynamics, between and among service users, staff, and other stakeholders.

Participants provided examples of how restorative practice is being embedded across a team or organisation, such as a social work team or children's home, both in processes such as restorative case conferences and social worker's everyday practice. Although not always integrated with other elements of restorative practice and the wider restorative justice field, it was noted that Family Group Conferences are used in many contexts including edge of care, safeguarding adults, mental health, substance misuse, and financial abuse.

We were told of the innovative use of restorative practice in the form of contextual safeguarding conferences in the community. These conferences give the community ownership in keeping their young people safe. Other new areas of practice are also evolving, such as no blame divorces with potential for restorative practice to have an impact.

Throughout the investigation, we learnt that social workers and families are dealing with increasing incidents of actual harm, loss or trauma which participants felt were not adequately being dealt with under current sector policies and procedures. There was support for the social care sector to draw from a depth of experience developed within criminal justice and better utilise restorative practice in addressing conflict and repairing harm.

**Impact**

There is little formal research evidence or randomised controlled trials data to support the benefits of implementing restorative practice within social care. Where this does exist, it was difficult to isolate restorative practice as the key agent of change, as it was typically used alongside other approaches. Some existing data does suggest significant cost savings, for example from helping a family stay together, or keeping a young person out of the criminal justice system however, investment in research is needed to better understand this.

It was noted within one research report investigating the impact of the Department of Education Children's Social Care Innovation Programme that the introduction of restorative practice can significantly impact on struggling local authorities. In one example it was stated that 'A local authority's children's services were rated inadequate by OFSTED. The introduction of restorative practice has helped to address the issues. It is now graded as improved.'

Gathering evidence of the impact that restorative practice is having across the social care sector was problematic. As a new and developing area of practice, there are currently no specific criteria to measure success against. Subsequently, impact data is either incidental or

measured against existing key performance indicators. Participants told us that existing data collection systems, quality assurance and audit processes could capture some aspects of impact. This included existing key performance indicators such as the number of:

- Children requiring statutory intervention from children's social care and therefore social work caseloads
- Children entering and leaving care
- Children on Child Protection or Child in Need plans
- The number of looked after children reported to the police for incidents within care homes
- Adherence to plans
- Re-referrals for safeguarding or domestic violence
- Missing incidents
- Staff retention, sickness and absence
- Complaints from service users and grievances from staff received

However, participants also felt that more qualitative data of the use of restorative practice could be captured by social workers within their assessments, case notes and formal reports. Other examples of qualitative data included a greater use of case studies and gathering feedback from service users.

Given that a major focus of restorative practice within social care is relationships, measuring how working restoratively impacts on children, families and staff is challenging. Participants felt strongly that it is important to measure the positives, not only a reduction in negatives, and that both quantitative and qualitative approaches are needed.

**'We need to resist the desire to measure everything using quantitative data of various kinds. What is measurable is different from what is important.'**

Participants suggested that 'important' data to capture should include:

- Whether a meeting or plan is collaborative/ owned by the service user/ includes the service user's voice/ places emphasis on the service users' wishes
- Hearing the service user voice, including in focus groups
- Better emotional literacy, greater problem-solving abilities for service users
- Social worker confidence
- Listening skills of staff
- Improved relationships
- Better future life opportunities for service users

**Obstacles**

In line with the evidence gathered for education and health settings, gaining senior leadership buy-in was seen as a significant obstacle to embedding restorative practices across the social care sector. Many participants told us that a commitment to restorative practice can often disappear if senior leaders change.

Another significant obstacle was the challenge of making both culture and behaviour changes in a well-established system. Participants highlighted that even where teams were working restoratively, this was not necessarily consistent or by design. Making a culture shift of this magnitude will take time, perseverance and determination. This was further supported by evidence which suggested that there is a general lack of clarity about what restorative practice could or should look like within social care. Participants agreed that there needed to be a clearer, more cohesive narrative as to what restorative practice in social care is and how impact can be measured.

Without this clarity, there is a risk that social care staff believe they are already 'restorative' and therefore avoid further training and, in some cases, continue working in a punitive and non-restorative way. Likewise, it was highlighted that the social care sector cannot work in a silo. Other organisations with whom social care staff must engage, also need to work restoratively. There was a consensus that consistency across agencies is vital if this approach is to deliver maximum benefit for children and families.

It was recognised that existing data systems are not suited to recording the use restorative practice; subsequently systems to monitor impact also do not exist. Unlike the criminal justice sector, a dedicated restorative practice recording system is not in widespread use.

Participants also expressed concerns that without funding to support implementing restorative practices it is unlikely to become widely adopted. They also shared concerns that without statutory funding, there was an increased risk of restorative programmes being cut if cost savings needed to be made.

Likewise, participants felt there is the potential for resistance to this type of approach particularly if it is not mandatory. Several participants told us that 'it takes time to build relationships' and, given that caseloads are typically high, time pressures faced by social care staff could also impact negatively on the implementation of restorative ways of working.

## 6 Key Recommendations

1. Fund the commissioning of a pilot study covering England, Wales and Northern Ireland to assess the costs and benefits of adopting restorative practices in each of the education, health and social care sectors.

2. Invest in a co-designed review of the relational aspects of our current Education, Health and Social Care systems in England and Wales to inform the development of a cohesive government strategy for the longer-term implementation of restorative practice.

3. Fund the development of an evidence-based good practice guide to successful implementation of restorative practice in each of the education, health and social care sectors, making use of the literature review conducted for this Inquiry and the evidence submitted to this Inquiry.

4. Fund the development of evaluation instruments capable of capturing both successful implementation and impacts of restorative practice in each of the education, health and social care sectors.

5. Within Education, encourage the guidance provided through the Behaviour Hub programme to adopt a more trauma-informed, restorative and less behaviourist, punitive approach to behaviour and relationships in schools.

6. Within Health, support the development of a UK National Advocacy Service, led by independent advocates trained in restorative practice, to offer restorative processes to resolve issues caused by medical mistakes and negligence whilst supporting both staff and harmed patients and their families

7. Within Social Care, invest in further research into the use of restorative practice in both adult and children's services including the cost savings of keeping families together and potential benefits of restorative practice in delivering equality diversity and inclusion policies and reducing disparity.

## 7 Acknowledgements

We would like to thank all those who submitted evidence to this investigation. In particular, we are grateful to those who provided oral evidence to the All-Party Parliamentary Group including:

Dr Dan Reisel, University College London Hospitals NHS Foundation Trust
Janine Carroll, Restorative Now
Molly Macleod, Gloucestershire Local Authority
Joanne Hughes, Harmed Patients Alliance
Simon Saxton, North Yorkshire County Council
Janice Nicholson, North Yorkshire County Council
Shannon Ki-Clayton, North Yorkshire County Council

## 8 References

1 - Zakszeski, B. & Rutherford, L. (2021): Mind the Gap: A Systematic Review of Research on Restorative Practies in Schools, School Psychology Review. https://doi.org/10.1080/2372966X.2020.1852056
1 - Darling-Hammond, S., Fronius, T.A., Sutherland, H. et al. (2020). Effectiveness of Restorative Justice in US K-12 Schools: a Review of Quantitative Research. Contemp School Psychol 24, 295–308. https://doi.org/10.1007/s40688-020-00290-0
2 - Procter-Legg T. Practitioner Perspectives on a Restorative Community: An Inductive Evaluative Study of Conceptual, Pedagogical, and Routine Practice. Laws. 2022; 11(1):4. https://doi.org/10.3390/laws11010004