**Transcript for video: What’s happening locally by Jacqueline Ryan, mental health and addiction quality improvement programme**

I'm a quality improvement advisor with the mental health and addiction quality improvement programme at the Health Quality & Safety Commission.

The mental health and addiction quality improvement programme is a national five-year programme funded by the district health boards and hosted by Health Quality & Safety Commission.

It is comprised of five priority areas identified by the mental health and addiction quality improvement sector.

One of the priority areas within this programme is the learning from adverse events consumer, family and whānau experience project.

This project began in March 2019 with preliminary workshops with mental health and addiction sector leaders held in March and June of that year.

As part of these workshops we looked at organisations and their existing processes for adverse events: what is the problem with their organisation's adverse event review processes from their perspective and what does good look like?

A six-month co-design phase with 20 DHB project teams started in September 2019, followed by an 11-month quality improvement phase from January to November 2020.

Key messages and themes from the preliminary workshops and the co-design phase involving consumers, family, whānau and staff included limited learning and lack of processes to disseminate learning from reviews within organisations and across the mental health and addiction sector, inconsistent involvement of health care consumers, family and whānau in the process and concern that the adverse event review process may perpetuate or increase harm, particularly to whānau and staff rather than address harm.

Additionally, in August 2018, the Ngā Poutama quality in context in mental health and addiction services national survey found that only 35 percent of mental health and addiction staff in DHBs reported that learning from adverse events had led to positive change in their organisation.

Two thousand five hundred and sixty-four staff responded to the survey.

Restorative practice was introduced to mental health and addiction sector leaders and project teams as part of the learning from adverse events consumer, family, whānau experience workshops.

As part of a Masters degree at the University of Auckland and linked to the learning from adverse events consumer, family, whānau experience project, a semi-structured interview study was conducted with 21 key stakeholders including mental health and addiction clinicians, managers, advisors, specialists, academic leaders and consumers.

The aim of the study was to explore the potential of restorative practice to improve the experience of participants in the mental health and addiction adverse event review process with a view to better meet the needs of consumers, whānau and staff involved.

As part of this study some major themes emerge, suggesting dissatisfaction with the current mental health and addiction adverse event review process, including that it has become lengthy and resource-intensive.

It may fail to engage consumers, whānau and staff.

Consumers often felt that they were not heard or meaningfully involved and that staff found the adverse event process adversarial and blame-focused and the current adverse event responses may compound the harm for all those involved.

Most participants recognise the opportunity to improve the current process by identifying alternative approaches with the potential to improve learning from adverse events while also meeting the needs of all those affected.

Some participants had heard about restorative practice through the Ministry of Health work on hearing and responding to the stories of survivors of surgical mesh or from its roots in Māori traditions such as hohou te rongopai, or peace-making, which we have heard about.

In New Zealand, restorative practices have also been used in justice settings since the 1970sand more recently in the education system and the police.

More than half of participants thought that restorative practice had potential to improve the review process after an adverse event including better meeting the needs of the consumers, whānau and staff involved.

Also that it could complement the current review process rather than seeking to replace it and provide additional capacity to learn from adverse events at the organisational level.

Māori participants had specific views that restorative practice will be beneficial for Māori with the proviso that it is led by a best-practice approach with tikanga Māori expertise so people feel confident and able to implement it.

As part of the learning from adverse events consumer, family, whānau experience project and following the interview study, DHB project leads and sponsors were asked to indicate their interest in exploring the restorative practice approach further with us in 2021.

In partnership with subject matter experts from the Diana Unwin Chair in Restorative Justice, we are working with four self-selected district health board project teams.

We are using a learning session model, building on the work already done by project teams in the co-design and quality improvement phase of the adverse events project.

The restorative practice content is tailor-made, responding to the needs of DHB project teams and focused on introducing the restorative approach and associated practices, including circles, the talking piece, restorative questions and the preparation required, introducing hohou te rongopai, looking at the critical success factors for restorative response to an adverse events and allowing participants to experience some of the practices and principles for themselves.

So far we have held one learning session and one coaching session with the four DHB project teams.

Learning session 2 was due to be held on the 1st of September but has been postponed because of COVID and we're hoping it will take place in person on the 24th of November.

Some initial impressions are that restorative practice is different for different people and that there needs to be flexibility in the approach to adapt to the group you're working with.

Some participants were more comfortable with the practices than others; perhaps the deliberateness of the process and first questions felt contrived.

Some liked the talking piece; others didn't.

Some liked the connection circle questions; others found these questions too personal.

We've also learned about the importance of tikanga in these practices, particularly when working with Māori.

Following Māori tikanga completely in opening sessions and incorporating it throughout is important.

That's where approaches like hohou te rongopai are essential.

The four DHBs and the organisations are at different stages of openness and readiness to explore the approach and what they are currently doing and how restorative practices could be integrated into their current adverse event processes.

We also know that restorative practice isn't a see-one do-one technique; it requires skilled facilitation.

Opportunities expressed by project team members are that it seems like a better way to respond to families within adverse event reports and processes.

They see it's relevant from team culture through to complaints and adverse events that the inclusiveness and respect components are universal and that they want to think more about embedding proactive practices to build relationships as well as repair the harm.

I'd like to conclude by sharing a quote from one of the Māori participants of the interview study.

'Restorative practice is about restoring the mana and dignity of whānau as well as the treating team. It is about how to improve and repair relationships of the harm done to face up and be part of the process.’

Tenā koutou, tēnā koutou, tēnā tatou katoa.

Thank you.