How to make restorative practice more inclusive

Ensuring that restorative practice is inclusive may involve adapting current practice, developing creative solutions to participation problems, and sharing practice that works with other practitioners. These measures can enable those participants who have additional or special needs to fully participate in and benefit from a restorative process.

This guide offers a starting point for practitioners thinking about working in an inclusive manner. It explains what inclusive restorative practice is and what the barriers to inclusion might be and offers a simple framework for emerging inclusive restorative services and individuals. It also lists creative ideas that practitioners might use to adapt existing practice.

What is inclusive restorative practice?

Inclusive restorative practice is best understood as a way of thinking about how facilitators manage restorative processes and identify and remove barriers to participation. Facilitation which utilises collaborative and creative solutions, without compromising core restorative principles, is central to an inclusive way of thinking.

Throughout this guide the term 'learning disability' is used to signal a range of prior needs that a participant may have that are outside of the needs specifically created by harm. These 'other' needs could be learning difficulties and may include language delay or impairment, autism, hyperactivity, dyslexia and other special educational needs recognised in educational settings. Young people and adults with learning disabilities in workplace, leisure, and indeed justice settings will face a wide range of challenges in a world of systems that are largely designed by non-disabled people. Additional needs such as social and physical wellbeing, medical needs, or the specific issue of attachment are not addressed here. Physical disability and sensory loss is also not addressed in this guide.

From the outset of a restorative process both those who have been harmed and those accepting some responsibility for the harm may present additional or special needs beyond those needs created by harm. These additional needs can be of a physical, sensory, emotional, psychological, cognitive, or medical nature. Some individuals will have a specific diagnosis or named condition such as Asperger's Syndrome, Down's Syndrome or Attention Deficit Hyperactivity Disorder (ADHD). Some practitioners may be familiar with the community support needs of individuals with a disability or additional need but may have no direct experience of providing appropriate support throughout a restorative process. Other conditions may be less familiar to practitioners and may involve speech, language and communication needs or specific learning difficulties.

Individuals may have special needs or disabilities which are hidden and have never been identified or acknowledged through a formal clinical assessment. The observant restorative practitioner may notice unusual patterns of behaviour or a particular way of using language, for example. Either of these could indicate the possibility that a participant could find a restorative process a particular challenge over and above what might normally be expected.

Practitioners are invited to be careful observers of what individuals say and do from the outset of any restorative process. Sensitive observation will enable practitioners to identify possible barriers

to participation which can then be overcome using creative practices. In summary, an inclusive approach to restorative processes involves:

1. Observing what people say and do.
2. Using the APEAL framework for planning.
3. Maintaining restorative principles when adapting practice.
4. Developing creative solutions.
5. Sharing practice that works with other practitioners.

Restorative principles alone do not necessarily ensure the inclusiveness of restorative practice. Inclusive practice is not simply a matter of physical access, nor is the formulation of an inclusive statement or policy or the expression of an intention to 'include everyone' sufficient. Inclusive restorative practice needs to be explicit rather than implied in order to deliver equality of access and participation.

Why is inclusive practice needed?

The 2008 Prison Reform Trust report, No One Knows: Prisoner Voices, explored the experiences of prisoners with learning difficulties or disabilities. The report identified that 20-30 per cent of all prisoners had learning difficulties or experienced a disability, although this only related to diagnosed conditions and may therefore be regarded as a conservative figure. This report also highlighted that 70 per cent of prisoners suffered from mental health disorders. A 2013 report on the criminal victimisation of people with mental health problems found that 29 per cent of people with severe mental illnesses had been victims of assault. In 2012 the Surveying Prisoner Crime Reduction survey found that over one third of prisoners had some form of disability.

In 2010 another Prison Reform Trust report, Seen and Heard, identified that 23 per cent of young offenders had an IQ of less than 70 and that 25 per cent of young offenders had special needs. Evidence given to the House of Commons Justice Select Committee in 2013 claimed that an estimated 60-65 per cent of young offenders have speech, language and communication needs, 24-30 per cent have a learning disability and the majority may not understand essential words such as ‘victim’, ‘breach’, ‘guilty’, ‘liable’, ‘remorse’ and ‘conditional’.

In 2011 the crime reduction charity Nacro reported that while a quarter of young people in contact with youth justice teams had special needs, only 60 per cent of them were in possession of a statement of educational need. It also found that 42 per cent of these young people showed indications of under-achievement, a factor which the report noted, “could be indicative of an unidentified speech, language, and communication need”.

Given the relatively high proportion of young offenders having a language impairment or delay, the greater likelihood of people with disabilities being victims of crime and the high proportion of prisoners with a mental health disorder, a learning disability or with special needs there is a clear need for restorative practice to be more explicitly inclusive.

What are the barriers to inclusion?

When a restorative practitioner accepts a referral or invitation to facilitate a restorative process practitioners adhering to the RJC standards engage in a period of reflection and will be well aware of the importance of evaluating various aspects of risk. Correctly assessing and managing

risk in each case ensures that restorative processes are conducted under safe conditions which minimise the risk of further harm being caused.

Practitioner experience and disability awareness

The individual practitioner's own unique experience and awareness of disability and special needs will determine how they view the risks involved when working with an individual affected by or responsible for harm. For example, if the prevailing view within a service or of an individual practitioner is that a perceived lack of empathy from an individual with Asperger's Syndrome or high functioning autism signifies a risk for the process, then access to the restorative opportunity will be restricted. Perceptions of what is possible together with disability awareness will affect a practitioners' view of risk.

When additional and special needs are viewed as a barrier to being offered the opportunity of a restorative process, this may be because the practitioner's awareness of disability is limited or there may be a prevailing belief in the service that only 'specialists' can work restoratively with any individual who is different. It may also be a lack of awareness around the benefits of being creative with restorative practices.

Memory impairment

An individual with a learning disability may have difficulty describing events; recalling the chronology of a set of events; or organising their thoughts into a coherent story that can be shared. They may also remember events that have no bearing on the main event or they may prioritise the remembering of certain aspects in excessive detail. For example a person with autism may remember and prioritise details of what colour and make of sweatshirt a person was wearing but not remember what that person said or did. Other difficulties may arise when the individual has trouble distinguishing between a memory from their own direct experience and a memory of a visualisation of what someone has described or said to them.

Temporal sequencing

An individual with temporal sequencing difficulties will struggle to retell the chronology of a series of events. They may not know where to start, may not be able to explain events logically or coherently; and may have an insufficient grasp of temporal language - for example, 'first', 'next', 'after that', 'later', 'then', 'before that', 'at the same time', and 'a long time after'. Their story could sound muddled. They may appear to alter their story more than might be expected or they might continually return to certain parts of the story to get their bearings. This may give the perception of falsity or unreliability as they struggle to explain. The listener will be aware of having to concentrate harder than usual to understand what is being said.

Exclusive restorative language

There is a range of specific language which is used in the various elements of restorative practice including restorative conversations, restorative circles, scripted conferencing, and restorative enquiry. The conventional language used in each of these elements may present a unique issue for participants with disabilities. This relates particularly to the construction of, vocabulary used in, and word order of a given question.

A person with language delay or impairment may have difficulty understanding what is said to them, expressing their experience in a coherent manner, communicating verbally or in writing,

visualising scenarios when unfamiliar language or concepts are used or describing thoughts or feelings due to a limited vocabulary. They may also become frustrated and give up or storm off. The listener may become aware of a limited range of vocabulary used - a lack of descriptive detail; an over use of certain words or phrases or an apparently muddled or simplistic description. The listener may note deletions, distortions, exaggerations or other unintentional inaccuracies which may be features of any story told by a person with impaired communication skills.

Specific examples of restorative language that can be problematic for some people with disabilities include:

- "What happened?" and "how did it make you feel?": a person with autism may have difficulty separating out thoughts and feelings when responding to these questions. Indeed, many people without any significant disability when asked what they were thinking will respond with what they were feeling or vice versa.
- "How have you been affected?" and "who else has been affected?": these questions require the respondent to scan any direct experience that they have committed to memory, analyse it for 'affective' traits then synthesise the relevant information in order to summarise and describe it. This can be highly challenging for a person with a learning or language disability.
- "What needs to happen next?": this question requires a certain amount of imagination and visualisation as to what might be possible. Working together on a solution that could repair or reconcile a relationship, or return the individuals to a 'right relationship for strangers' requires language skills that may need to be supported.
- 'Affects' and 'needs' generally: both words are of key significance to restorative processes yet both have complex and layered meanings. Both words may involve a physical, emotional, psychological, financial, sexual, or social element, or any combination of these and both can be temporary or permanent. 'Affects' and 'needs' may be hidden or unknown or attributed to one event but have their root cause elsewhere. In addition, those needs expressed by some people with disabilities may appear to be very particular or unusual. An autistic person who has experienced harm may need something quite unusual to happen for them to feel safe in the future - for example, the performance of a ritual or a particular security object being replaced in its original state (including the replication of original marks or smells).

Non-engagement

Participant access and participation alone are insufficient to enable the harm to be repaired in any restorative process. Full engagement is necessary for transformation in the thinking of the harmer, potential repair of harm, opportunity for needs to be expressed and heard and the possibility of reconciliation (Braithwaite 2002).

While the aim is for the individuals more directly affected by the harm to be fully engaged in the restorative process, it may be the case that an advocate or carer is more appropriately placed to adopt this role. An example may be when harm has been caused by a person with a learning disability who is unable to understand the consequences of their actions and where preventative measures, policies or procedures were not followed in order to protect that person and others. If, during the restorative conference, a participating carer or key worker wishes to take some responsibility for harm that has been caused, the facilitator is advised to ask those affected by harm if this is acceptable to them. A new care plan may be the outcome in this type of case.

In this instance it may or may not be appropriate for the person with the learning disability to participate in the restorative encounter - this will be dependent on the particular circumstances and people involved. As is standard practice, the risks of further harm being created by a restorative process will be assessed by the practitioner.

How can restorative practice move towards being more inclusive?

The APEAL framework

A access

P participation

E engagement

A actions agreed are supported

L leadership (of service users)

The APEAL framework, developed by inclusive practitioner and trainer Bonita Holland, allows the restorative practitioner to consider inclusive practice in relation to each unique case and to use their professional judgement and experience to plan support and follow-up. Bonita developed APEAL following thirty years' experience working in the field of disability and special needs and recent experience of using a restorative approach with young people with additional and special needs.

Access

Issues of physical access are declining in frequency and tend to be more straightforward to manage. Physical solutions are becoming better known such as the provision in buildings of larger doorways, permanent ramps and handrails, easy access disabled toilets, adaptive seating and IT equipment and sensory support adaptations. Prospective participants or their carers are likely to be well-versed in expressing their needs for large print if visually impaired, or for the practitioner to ensure full face communications if lip reading is to be used to support hearing. The practitioner is advised to consult the participant and carers in the first instance as the participant's personal knowledge and first-hand experience of their own condition should be fully utilised when planning any support.

Rules and expectations

When a practitioner first meets with a harmed person or the person taking responsibility for the harm, the outcome might be an agreement with the facilitator to explore the possibility of arranging a face to face encounter with the other person or persons affected by an incident or events. Experienced practitioners will inquire as to what might be needed to ensure that the person feels safe or secure or able to participate and engage with any direct or indirect encounter or process. What may emerge from the discussion is a request for certain rules or expectations to be met. Examples of agreed behaviours for a meeting can include taking turns to speak, no interrupting, no swearing or disrespectful name calling, mobile phones turned off, no standing up or disrespectful gestures and no threats. Other agreed arrangements could include sitting in a circle, adhering to a particular seating plan, the order in which each person speaks, who will be present during a face to face meeting and any other actions to meet expectations and ensure safety.

A 'no interrupting' rule may be agreed but a person with ADHD may find it very hard to stick to without specific support. Sitting still and not fidgeting may also be easy enough to agree but may be hard to maintain for very long. Sitting in a circle may be the preferred approach of a

practitioner, but the degree of eye contact this creates can be hard for the person with autism or others with a social phobia. Extended periods of time given to talking and listening may be hard to cope with for a person with a language impairment. Various techniques can be employed to support individuals - the use of a glove which is put on when someone wants to speak, the use of gaffa tape to mark an oblong on the floor around a seat as the boundary for pacing and the use of visual icons on a small poster for agreed rules. Providing an elastic band or Blu Tack for fiddling or using a small wastepaper bin as a turn taking object pushed by foot from person to person may also be helpful.

Participation

When an individual is invited to participate in a restorative process, practitioners adhering to good practice will clearly explain what participants can expect, what might be expected of them and what the process will involve. For the participant with additional special needs or a disability, a carer or adult advocate may be invited to participate even if they have not been directly affected by harm. Their role is not necessarily to share how they have been affected, but to directly support the individual in order that they can engage as fully as possible. Facilitators will need to carefully plan encounters where a participant has an advocate or carer supporter, and to develop clarity for all involved regarding roles and responsibilities. Adults with a learning disability generally manage their own support budget, and may employ a support carer or service. Practitioners are advised to ask about these various arrangements in order to identify the best way to support the adult with a learning disability.

Engagement

Practitioners who effectively support engagement with the process can have a significant impact on the outcomes of inclusive restorative practice. Adapting aspects of the restorative process to be more inclusive without compromising core restorative principles may be least challenging for practitioners with considerable experience of disability. However, less experienced inclusive restorative practitioners can support themselves and colleagues by sharing explicit inclusive practice through professional networks. This creates sustainable inclusive structures within services and organisations which build the capacity of local practitioners. Specialist training in inclusive restorative practice is available in many areas of the UK and when shared more widely will raise local and national awareness of what is possible. The Restorative Service Quality Mark includes a requirement across all six criteria for services to be inclusive.

Changing the language used when asking about thoughts and feelings can support engagement. Examples include:

- What were you thinking?
- How did you feel when that happened?
- What have you thought about that since?
- What do you feel about that now?
- What did that make you think?
- What thoughts went through your head?
- Are you able to share your feelings about that?
- Are you able to describe what you were thinking then?
- What was in your mind?
- What was the plan?

- What made that difficult?
- What was hard about that?

A person with autism who is unable to respond to questions about feelings can be invited to describe specific physical sensations - which can be indicative of feelings - that they associate with specific past events. Using simple drawings of physical sensations may support individuals with limited emotion or affect vocabulary, and inviting them to recall what they said or did later may allow others to work out what might have been in their mind at an earlier time. A person with limited temporal language may require support distinguishing which thoughts and feelings are associated with which events in time. A visual time line is particularly useful to support this aspect of the process. A person with a language disability may have a limited vocabulary with which to describe thoughts or feelings, but they may be more capable of describing in detail their physical bodily reactions. If bodily sensation drawings are placed next to the time line, thought bubbles can then be placed above the time line. In this way a narrative picture can be built.

Actions agreed are supported

For the person with a disability any future actions they have committed to will almost certainly require support. At the time of making an agreement of commitments, it is advised that the facilitator identify what is needed to ensure that the actions agreed can indeed happen.

Leadership of service users

The involvement of participants with a disability in the shaping and development of a service wanting to develop inclusive restorative practice is essential and will always be beneficial. Ways restorative services might seek to involve principal participants, supporter advocates, or affected parties may include seeking input on the following:

- Providing insight into what might have helped the individual at various points in the process.
- The possibility of making a contribution to training or professional development activities.
- Sharing personal insights with a local practitioner network.
- Being included in the short-listing stage of a recruitment process.
- Providing a suitable question for an interview panel.
- Being able to contribute to the development of a restorative service.

The importance of sharing inclusive best practice

At a national level there are many organisations who are able to provide general advice and guidance regarding disability to restorative practitioners but it is the practitioner themselves who must incorporate guidance and best practice into their planning for an individual case. Local partnerships and other structures which enable the sharing of disability awareness and creative practice will help build the capacity of colleagues and sustain inclusive best practice.

What are some creative ways of making restorative practice more inclusive?

There are simple ways in which experienced practitioners can enable participation and engagement when a participant in a restorative process has additional or special needs or a disability that affects their capacity to engage with the process. The following examples are

offered as prompts for professionals to reflect on rather than a definitive list and are organised in broad groups of behavioural needs rather than in relation to any specific vulnerable group.

Examples of inclusive practice addressing language needs:

- Graphical depictions of rules. For example, a two-by-two grid showing no mobile phones, each person taking turns to speak, no swearing or name calling and everyone remaining seated.
- Seating plan diagrams indicating who sits where and the nature of their role in the process.
- Process diagrams including symbols to represent first, second, next, after that, then, and last of all that enable participants to understand the process.
- Needs circles consisting of a quartered circle with illustrations in each quarter representing internal organs (sensations and needs), money signage (financial needs), a head with a cross-section of a brain (psychological needs), and a body outline (external social or physical needs).
- Thinking frames that include key questions such as: “What's in it for me?”, “What was in my mind?” and “What was the plan?”
- Listening frames that include key words to listen for like hurt, upset, angry, affected and care, and phrases such as “I'm sorry”, “I apologise”, “I want things to be better” and “I didn't realise”.

Examples of inclusive practice addressing memory and sequencing needs

- The simple drawing of a line can considerably aid communication of when particular events might have occurred and support the use of temporal language. The beginning dot represents a time when life was okay for the individual - practitioners may find it useful to ask the individual to talk about a time when things were good or OK. The X marks the harmful event - far past and near past language can now be used to locate events between life being good and the harmful event. These events can be represented by triangles while circles drawn after the X can indicate what has occurred since the harmful event.

- Timelines and schedules may also be useful which may include times throughout a day, days of the week, dates, parallel time lines for different people involved and intersections, the use of illustrations depicting thoughts and feelings associated with timeline events and the use of digital and analogue clock depictions.
- A post it note can be used to cover the X until and individual is ready or able to talk about the event or the hardest thing on the line.

Examples of inclusive practice addressing access and participation needs

- Incorporation of items intended to support service-users, for example a highly valued personal item.
- Masking tape or gaffa tape to delineate a seating or standing boundary.
- Talking pieces respected by all (for example, a £20 note) or talking pieces that are safe and easy to hold such as a rolled up hand towel or a scrunched up piece of paper. Talking pieces that aren't hand-held such as a traffic cone or wastepaper basket can easily be passed between people by pushing with a foot.
- Improvised objects that can be used to represent people such as buttons, coins, teaspoons, or small pebbles can be placed on a table or along the drawn time line.
- Items to fiddle with such as a stress ball, worry beads, an elastic band, Blu Tack or doodle pad and pen.
- Gloves which participants can put on to signal a desire to speak rather than interrupting.
- An iPad or smartphone or tablet apps are now widely available and can be used in many different ways to aid communication.

What are the next steps?

Access and participation may be a challenge to arrange, but an inclusive organisation and service will develop a package of practical solutions that are effective. New practitioners are encouraged to ask about the arrangements and resources available from within a service that make the offer of restorative process possible for a wider range of people. Partnerships within localities are to be encouraged, together with the sharing of disability awareness and expertise with local restorative services. On a national level there are many organisations who are able to provide general advice and guidance regarding disability to the practitioner of restorative practice, but it is the facilitator who must incorporate this guidance into their inclusive planning for an individual case.

Restorative trainers

A three to four day restorative facilitation training course should include a minimum of one unit or one two hour session that addresses explicit inclusive restorative practice and that builds on practitioner awareness of additional and special needs, learning difficulties, and disability. Any trainer-issued guidance on participant access should be based on the need for disability awareness training as part of restorative facilitation training.

Managers of restorative services

The APEAL framework should be used in the development of any restorative service or organisation.

Managers should take responsibility for developing an access framework (APEAL) based on inclusive restorative practice which highlights the importance of practitioner experience and disability awareness for access decision-making.

Restorative practitioners

When planning any support, practitioners should in the first instance consult participants and their carers or advocates in the first instance in order to fully utilise their personal knowledge and first-hand experience of their own condition.

Practitioners should share effective restorative practice within professional networks.

Researchers
Researchers are encouraged to identify the prevalence of disability in any evaluative research of restorative practice.

Victims of harm, those responsible for harm, and their supporters
All participants in restorative processes should share their support needs with practitioners, particularly those support needs which will help maximise engagement.

Inspectors of restorative organisations and services
Inspectors should monitor participant access; the reasons given for access decision-making; and the thinking around the non-inclusion of potential participants with disabilities based on a risk.

Further reading

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www.restorativejustice.org.uk