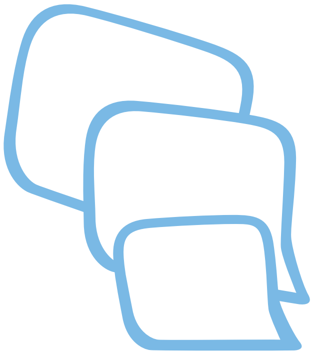
Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh

Kia ora te tangata: He arotakenga i te whakahaumanu
That all people would thrive: An evaluation of a restorative approach for addressing harm from surgical mesh

VICTORIA UNIVERSITY OF
WELLINGTON
TE HERENGA WAKA

The Diana Unwin
Chair in Restorative
Justice



Acknowledgements

We would like to express our deepest gratitude to all the people who have participated in this research. Thank you for trusting us again with your stories; it will always be our privilege to listen to New Zealanders affected by surgical mesh harm:

"The best vantage point for clarifying one's moral responsibility when harm has occurred is in the dirt and blood alongside the wounded party." – Chris Marshall*

Research team

This evaluation was prepared by researchers from the Diana Unwin Chair in Restorative Justice, Te Herenga Waka-Victoria University of Wellington. The Chair was established in January 2014 and serves as the focus for collaborative, interdisciplinary research and teaching on restorative justice theory and practice, both within the justice sector and beyond. The holder of the Chair, Chris Marshall, the Professor of Restorative Justice, provides academic and professional leadership to a team of researchers and practitioners, and facilitates collaborative engagement between public sector agencies and civil society organisations on restorative justice issues.

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* In Marshall, C. (2012). *Compassionate justice: An interdisciplinary dialogue with two gospel parables on law, crime, and restorative justice*. Eugene, Or: Cascade Books. p. 38.

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Executive summary

1. This report was commissioned by the Ministry of Health to evaluate the project 'Hearing and responding to the stories of survivors of surgical mesh: Ngā korero a ngā mōrehu – he urupare',[1] which used a restorative approach to listen to the stories of people adversely affected by surgical mesh. The project was conceptualised in terms of the individuals and relationships affected and helped the Ministry of Health to listen and understand the lived experiences of New Zealanders affected by surgical mesh harm in order to inform reparative action and prevent future harm.

2. The aims of this descriptive evaluation were to ascertain whether good practice was demonstrated by the project delivery team; to understand people's experiences of the process; to find out whether the project objectives were met; and to assess whether the approach was transferable to other health contexts.

3. A health impact assessment framework was chosen to assess the process and immediate impacts of a restorative approach. Participatory methods were used to design the research approach and data collection tools. Consumers, health professionals, responsible parties and workshop attendees were invited to participate. The COVID-19 pandemic delayed data collection, which eventually took place during May-July 2020. Ethics approval was granted by the Victoria University Human Ethics Committee.

4. The process evaluation determined that a restorative approach supported substantive, psychological and procedural needs to be met during the Listening and Understanding phase of the project. The preservation of dignity, validation of experience, and respectful communication was experienced by most people. The use of *proactive* and *reactive* restorative Circles and meetings were particularly effective. Inclusion of multiple methods for storytelling ensured that a safe and supportive environment was experienced by the majority. The impacts of surgical mesh harm were understood, and hearing the effects inspired responsible parties to collaborate and act for repair and prevention.

5. Consumers were largely unaware of progress on the 19 actions that resulted from the Planning and Acting phase of the project and wanted a swifter response. For these reasons, many consumers were unsure if their substantive needs would be met or if safer healthcare would occur in the future. Meeting the individual substantive needs of mesh injured consumers is essential to restore wellbeing. Apology and the provision of compensation and psychological support is vital to prevent compounded harm and restore relationships and trust. Restoring trust and confidence in the therapeutic relationship is essential for patient safety.

6. The COVID-19 pandemic delayed the delivery of the 19 actions agreed during the Planning and Acting phase of the project. Some actions, such as an ACC apology and initial review of declined claims, have occurred since data were collected. The results of the impact evaluation which aimed to determine the success of the Planning and Acting phase of the project and the extent to which the approach restored wellbeing and relationships should therefore be interpreted with the impact of COVID-19 in mind.

7. Restorative approaches and practices are potentially transferable to other health contexts if the critical success factors are met. Conflict resolution, adverse events, treatment injuries and consumer complaints were identified as key areas for exploration. Restorative approaches have the potential to meet substantive, psychological and procedural needs following an episode of healthcare harm in ways that many current approaches do not.

8. Healing after harm is possible when approached within a *relational* framework and this should be embedded alongside existing regulatory structures, policies, and procedural responses. The procedural adaptations enabled by a restorative approach should provide the person-centred approach expected. A collaborative approach to design, which distributes leadership amongst communities, advocates, and agencies, will promote success and build trust. Restorative approaches resonate with the relational approach of Te ao Māori and have more to offer Aotearoa New Zealand than traditional investigative methods.

9. The New Zealand Health and Disability System Review provides an opportunity to transform responses to healthcare harm in New Zealand. Ongoing testing and refining of restorative approaches in different contexts will be important to understand what works for whom, in what contexts and how. The identification of mechanisms that enable the success of a restorative approach in the context of the New Zealand health system is necessary if their potential is to be realised.

Introduction

This report was commissioned by the Ministry of Health to evaluate the project 'Hearing and responding to the stories of survivors of surgical mesh: Ngā korero a ngā mōrehu – he urupare'[1], which used a restorative approach to listen to the stories of people adversely affected by surgical mesh. The project was conceptualised in terms of the individuals and relationships affected and helped to clarify the Ministry of Health's responsibilities, and those of the wider healthcare sector, to inform reparative action and prevent future harm.

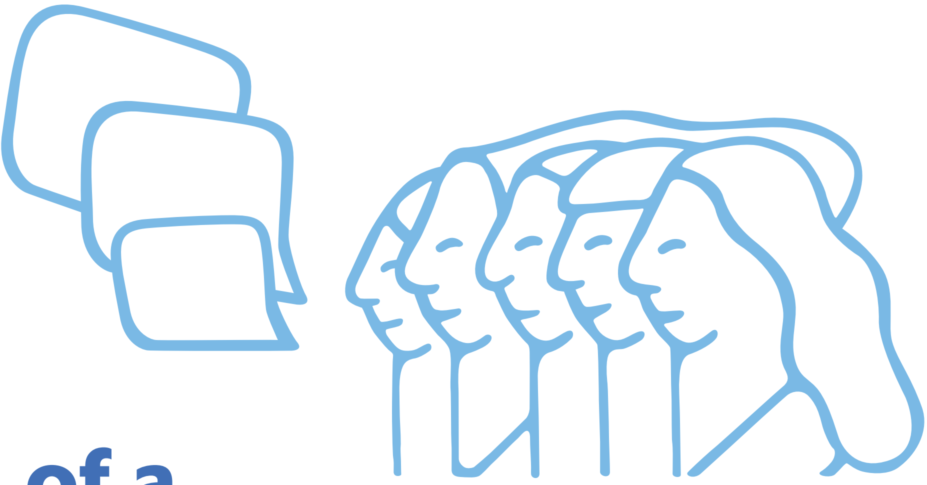
A co-design team for the project was formed in June 2019. It included representatives from the Ministry of Health, the consumer advocacy group Mesh Down Under (MDU) and the restorative justice team at Te Herenga Waka-Victoria University of Wellington. People's experiences were monitored during each phase of the project and the approach adapted in response to the emergent needs of individuals, groups, and entities.

Restorative practices were embedded in the co-design process and in the project design. The project was delivered in three phases from July to December 2019. The phases were: (i) Listening and Understanding, (ii) Planning and Acting, and (iii) Reporting and Evaluating. A description of each phase can be found in the project report.[1] The Mesh Round Table, a governance group led by the Ministry of Health, are responsible for implementing the 19 actions developed during the Planning and Acting phase of the project.[†]

Since a restorative approach has not been applied previously to healthcare harm of this scale, it is essential to understand the participants' experiences of the process and its impacts. Equally important is whether the project met its goals, demonstrated good practice and if it is transferable to other comparable situations. A critical evaluation is also necessary to establish legitimacy across stakeholders and to ensure accountability for using a novel process in a complex health environment.

The report is structured within a health impact assessment framework and is organised into four sections. The first two sections evaluate the process and impacts of the surgical mesh project, using the experiences of participants to describe what worked well and what could be improved. The third and fourth sections examine the factors that are critical for success, and the potential of restorative approaches in the healthcare context.

[†] Information about the Mesh Round table and progress to date can be found on the Ministry of Health surgical mesh website: https://www.health.govt.nz/our-work/hospitals-and-specialist-care/surgical-mesh



Principles of a restorative approach

A restorative approach to addressing harm is fundamentally relational in nature. It recognises that relationships make us human, relationships can be positive or harmful, and, if harm occurs, relationships are implicated in our healing.

Restorative practices can be both reactive and proactive in focus. That is, they can either respond to a harm that has already occurred or they can strive to create open, trusting and respectful relationships that can help to prevent or mitigate future harm.

There are two main ways to seek resolution when a conflict or harm occurs in healthcare settings. One is through a formal, adversarial process in which someone is assigned responsibility to investigate and/or adjudicate an outcome based on a legal framework or professional protocols. The other is through a non-adversarial approach in which solutions are sought through collaboration and consensus. Those affected by the harm and those responsible for the harm together determine what needs to be done for repair and prevention.

Collaborative, non-adversarial approaches are often called Alternative Dispute Resolution, in that they seek to function as an alternative to the formal system. Alternatives can take many forms, such as negotiation, mediation, arbitration, reconciliation, or restorative justice. These alternatives share many common features but are distinguished by the processes used, their underpinning values or principles and the outcomes sought. The key differences between a traditional investigative approach and restorative inquiry are outlined at appendix 1.

A restorative approach may be defined as a voluntary, relational process:

> *… whereby those with a personal stake in a harmful episode come together in a safe and respectful environment, with the help of skilled facilitators, to speak truthfully about what happened and its impact on their lives, to clarify accountability for the harms that have occurred, and to resolve together how best to promote repair and bring about positive changes for all involved.*[2]

All the affected parties are included because they are best placed to make suggestions about how to promote restoration and mitigate future risk. The process usually involves facilitated conversations between those who have been directly harmed by an episode and those responsible for the injury. Responsible parties are defined as individuals, groups or entities identified by the affected parties as having had a significant role to play in the occurrence of the harm and/or in the reparative and preventative actions required because of the harm.

The relational principles and values that underpin a restorative approach include active participation, respectful listening and communication, truthfulness, accountability, empowerment, and equal concern for all parties. The goals of the process are to clarify what happened in the past and its human impact and identify the needs it has created.

Collaborative decision-making enables all those involved to decide together how best to promote repair and achieve positive changes in the future. The central aim is to restore well-being rather than to reach a negotiated settlement or mediated agreement. Accordingly, the dialogue is guided by concern to address *harms*, meet *needs*, restore *trust*, and promote *repair* or healing for all involved. Appendix 2 illustrates how principles were applied in the project to meet restorative goals.

Empathetic dialogue and compassionate hearing may emerge from restorative practices that bring people together in a safe environment for face-to-face dialogue to answer the four questions of a restorative inquiry (Table 1).

Table 1: Restorative inquiry framework

◇	Who has been hurt and what are their needs? (past focus)
◇	Who is responsible for the harm and what are their obligations? (present focus)
◇	How can harms be repaired and relationships made right again?
◇	How can we prevent it from happening again? (future focus)

Restorative practices used in the surgical mesh project

Restorative practices enact the underlying principles, values, and goals of the approach. Practices used in this project included Circles, facilitated meetings between individuals and restorative conversations. In each case, the practice encouraged storytelling, empathy, accountability, collaboration, expression of feelings and thoughts, and ideas for problem solving.

A Circle process involves a structured and intentional conversation in which people, sitting in a circle, respond sequentially to a question or questions posed by circle facilitators.[3] Speaking rights are conferred by use of a talking piece which is handed from person to person. The 'talking piece' is introduced by the facilitator and usually has a special meaning or value for them. Circle processes typically involve several rounds. Ground rules are introduced by the facilitators at the outset and usually include listening with respect, speaking openly and honestly from the heart, honouring confidentiality, and sharing the time fairly.

Proactive Circle processes, such as those used in the co-design phase, can be used to establish group norms, and create the conditions for difficult conversations to occur. *Reactive* Circle processes typically follow a restorative inquiry framework. The first-round builds connections and trust between attendees. The next rounds aim to uncover the harms and needs that have emerged from an event and support attendees to explore reparative and preventative measures. The final round is usually focussed on participants' strengths.

In a small number of cases where individuals were identified as being too unwell to travel to the Listening Circles, or had particularly complex needs, people were offered a private facilitated meeting in a hospital or a person's own home. People could also choose to provide a written submission to a 'story database'. The story database was designed using the same four restorative inquiry questions and there was an option to upload documents, videos, or images.

The aim of providing multiple options for storytelling was to create a safe and supportive environment where:

- Consumers, defined as the mesh injured and their family or whānau, could choose how to share the impacts of surgical mesh on their lives and make suggestions regarding how to repair and prevent the harm.
- Representatives of responsible parties could understand the harms and needs created by surgical mesh use and learn what could be done to restore wellbeing and relationships and prevent future harm.

Evaluation approach

Consistent with best practice in evaluation, the aims, objectives, and values of the project were established during the co-design phase (appendix 3). The evaluation aimed to:

- Ascertain whether good practice was demonstrated by the delivery team
- Understand people's subjective experiences of the process
- Find out whether project objectives were met
- Assess whether the approach could be successfully used in other contexts.

The design of this evaluation was based on a health impact assessment (HIA) framework which is defined by the World Health Organization (2020) as:

> **A combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population, and the distribution of those effects within the population.**[4]

This framework was chosen because of its fit with the project goal of improving the mental and physical health of New Zealanders harmed by surgical mesh, both in the short term and in the future. A central concern of a HIA framework is to ensure that the voices of all people affected are listened to and heard.[5] In shaping health outcomes, there is an explicit focus on equity, sustainability, social justice, transparency and public scrutiny.[6,7,8] A health impact assessment is therefore congruent with the restorative principles that underpinned the project.

The following evaluation is a process and impact evaluation of the surgical mesh project. A process evaluation is an essential part of designing and testing any complex intervention.[9] An impact evaluation captures or measures the immediate effects of a project, particularly in relation to its objectives.[10] The project's express focus on understanding the subjective experience and needs of participants means this evaluation is primarily descriptive in character and not a formal measure of clinical outcomes. An outcome evaluation, which assesses long term or systemic changes, is beyond the scope of this report because of the long timeframe involved.

The evaluation design incorporated the participatory methods and data collection tools associated with HIA.[5] When consumers were first contacted to participate in the surgical mesh project, they were invited to describe their hopes for the process. Their thoughts were captured in face-to-face meetings in the co-design process, at Listening Circles, and in the story database. Their responses were organised into themes relating to the study criteria (see appendix 4) and were subsequently used to construct the survey and interview questions for the evaluation. Table 2 sets out the HIA evaluation criteria for a process and impact evaluation and how they have been applied.

Table 2: Evaluation criteria

EVALUATION CRITERIA	STUDY CRITERIA	PARTICIPANT CRITERIA
Process A process evaluation focuses on the activities undertaken during a project and identifies whether intentions were achieved.[9]	The extent to which the primary objective of Listening and Understanding was met. How the restorative approach was experienced by the various participant groups during this phase of the project. Critical success factors are identified.	Participants can tell their stories in a way of their choosing and in a safe and supportive environment. Participants are prepared to attend a Listening Circle or meeting and provided with follow-up information. People feel heard, believed, and validated by the responsible parties and other consumers during the *Listening and Understanding* phase of the project. Collaboration and trust between advocates and responsible parties is built in the co-design process.
Impact evaluation An impact evaluation captures or measures the immediate effects of a project, particularly in relation to its objectives.[10]	The mesh evaluation addresses the extent to which the primary objectives of Planning and Acting and Restoring Wellbeing and Relationships was met. Critical success factors are identified.	The needs of those affected by surgical mesh harm are identified. Awareness regarding the severity of the harm and the risks associated with surgical mesh use is increased. The severity of the harm caused by mesh is acknowledged publicly by the Ministry of Health and other responsible parties. The Ministry of Health and other responsible parties commit to reparative and preventative actions during the *Planning and Acting* phase of the project. The actions identified will *Restore Wellbeing and Relationships*. Timely action and resourcing follow commitments made in December 2019.

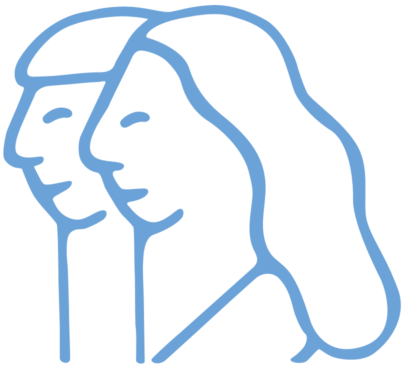
Methods

Data for the evaluation were collected between the May and July 2020. Consumers and health professionals who had participated in the surgical mesh project and indicated they could be contacted for research purposes were invited by email to take part in the evaluation by completing an online survey. Responsible parties who had attended Listening Circles and participants in the action planning workshop were invited to be interviewed. Additional data were drawn from a research diary and from the minutes of the co-design meetings. Ethics approval was granted by the Victoria University Human Ethics Committee (0000028500).

The survey instruments included demographic questions (age, sex, ethnicity and geographical region) and questions that used a 5-point Likert scale about consumer and health professionals' experiences of the Listening and Understanding process and their views about the impacts with respect to wellbeing and relationships. Respondents could expand on their views in the free-text fields that followed each question.

Numerical data were analysed using quantitative data analysis software (SPSS version 26). Where indicted by the qualitative analysis, data were tested using the chi-square test for independence to explore relationships between Likert question responses (details are at appendix 5). Interview and free-text survey responses were coded and analysed using qualitative data analysis software (NVivo version 12). Thematic analysis utilised a recognised inductive approach[11,12] until data saturation was met.[13] A consensus group met to discuss the initial findings prior finalising the report. Members of the consensus group are listed at appendix 6.

Who took part in the evaluation?



Consumers, health professionals, representatives of responsible parties and people that attended the Planning and Acting workshop were invited to participate in the evaluation.

Consumers

Of the 585 mesh injured people and their families or whānau that participated in the original project, 423 agreed to be contacted for research purposes. After deletion of duplicate and blank entries, 215 responses were included in the analysis, which is a response rate of 50.8 percent.

Figure 1 shows the age and sex of consumers: 77 percent are women, 23 percent are men, and three preferred to self-describe. Twelve were family, whānau or a friend of a mesh injured person. The ethnicity of respondents is shown at Figure 2. Other ethnicities reported were British, European, German, South African, and Dutch. Seventeen identified as Māori. Advice was sought from a Māori researcher and data were analysed separately. Findings were generally consistent with the experiences of non-Māori participants.

Figure 1: Age and sex

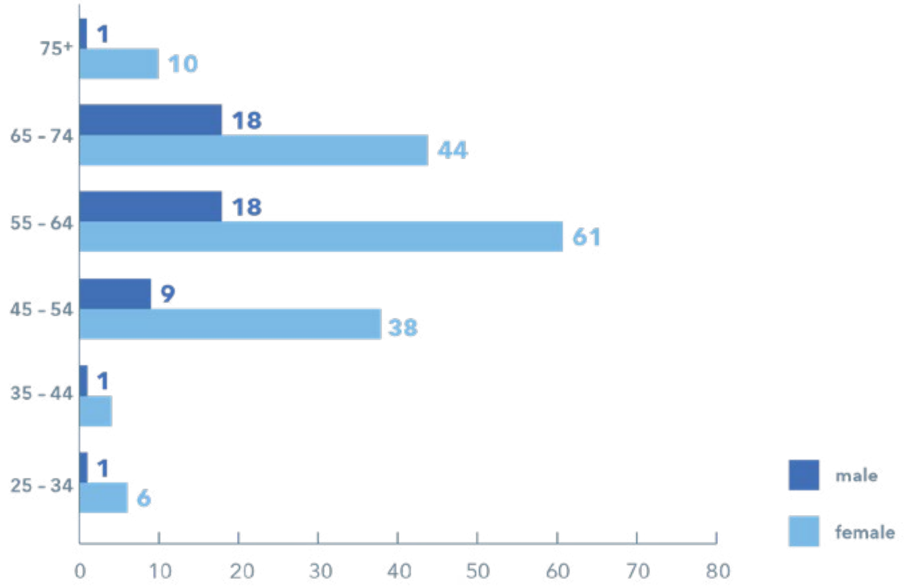


Figure 2: Ethnicity

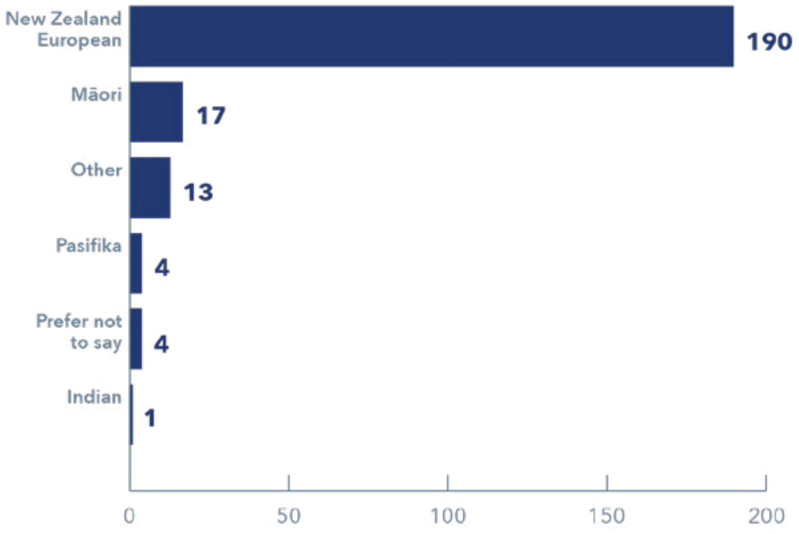


Table 3 shows the number of consumers who attended a Listening Circle, a private meeting, made an online submission, or chose a combination of those options.

Table 3: How consumers told their story

	Attended a listening circle	Submitted to the story database	Met privately with someone	Utilised more than one storytelling option
Mesh injured person	120	101	9	35
Family/whānau/friend of a mesh injured person	10	5	2	4
Total number of evaluation participants (original project participants)	**130** (249)	**106** (485)	**11** (14)	**39** (140)

The total number of consumers who participated in the evaluation is shown in bold and the number of consumers who participated in the original project is shown in brackets.

Health professionals

Of the 28 health professionals who provided a written submission to the story database in the original project, 16 agreed to be contacted to consider participating in an evaluation survey. The data were cleaned for minimal or repeat responses, leaving only six: three doctors, a physiotherapist, an acupuncturist, and a registered nurse. There were too few responses to report a meaningful analysis of the questions asked in this report.

Interview participants

Twenty-one people were invited to participate in an interview and 15 agreed. Invited parties included people who had attended Listening Circles as a responsible party and/or people who attended the Planning and Acting workshop. A total of 13 hours and 32 minutes of interview data was recorded and transcribed for analysis. To maintain confidentiality, demographic and role information is not detailed in this report. The interview participant group is representative of the diverse range of professional groups that participated in the project.

How was a restorative approach experienced?

The analysis of the survey data, free-text survey comments and interview data are presented together to illustrate the range of perspectives and experiences of the project design, process, and impacts. Charts showing the Likert responses (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree) are shown throughout the report and provide the following information:

- The number of responses (n). All survey questions were optional, and some were only asked of Listening Circle attendees. Including the number of responses to each question shows how many people answered each question.
- The median value (Mdn). The median is the middle value when a list of numbers is ordered from least to greatest. Including the median shows the value most people attributed to each question. For example, a Median of 4 (Mdn = 4) means that most consumers who answered agree to the question they were asked. A median of 3 (Mdn = 3) means that most consumers answered neither agree nor disagree to the question. The chart at appendix 5 shows the responses to all survey Likert responses.

Quotes from the interviews or free-text responses are used to describe the experiences of participants using their own words. Each quote has a unique identification code that indicates the source of the quote:

- Consumer: C (number) e.g. C165
- Interview participants IP (number) e.g. IP5
- Interview participants that meet the definition of a responsible party RP (number) e.g. RP3

The Process

Most survey questions relating to the process were answered positively (Mdn = 4), suggesting that the hopes for the Listening and Understanding phase of the project were, for the most part, achieved. Listening and Understanding was described by a participant as an important first step that should inform a procedural or investigative response to a harmful event:

> *"Rather than trying to jump straight to solutions, actually stand back and just listen. Listening would give far better insight into what people are really worried about and complaining about. So, I reckon [restorative responses should be] right at the front of the chain." (RP2)*

What worked well?

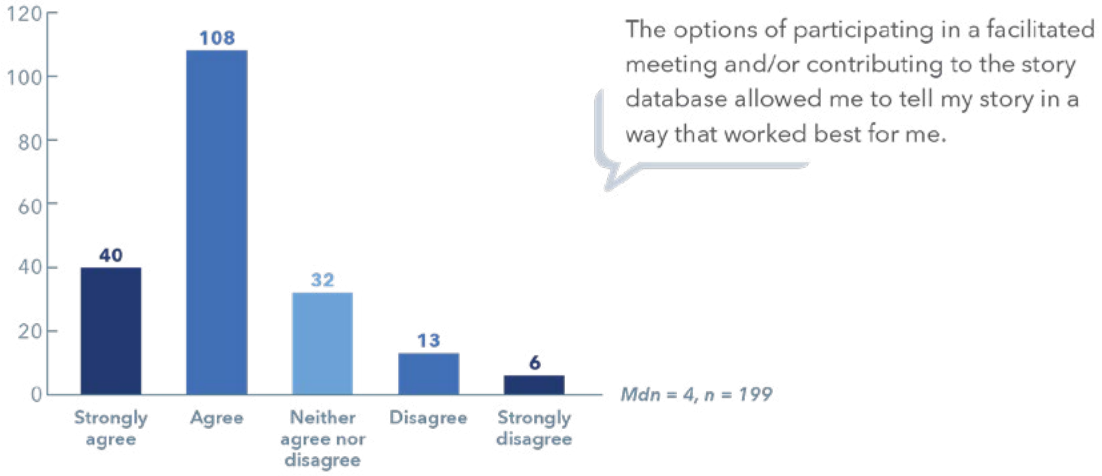
Prior to the project, the relationships between the mesh injured and government agencies and health professionals had become increasingly adversarial. Incivility and disrespect were common in a context that was described as paternalistic and hierarchical by both consumers and responsible parties. Proactive restorative practices used during the co-design process created the conditions for collaboration and rebuilt trust. Independent facilitators and distributive leadership created the conditions for equity of voice:

> *"I think [a restorative approach] is enabling those injured, however they may be injured, [to] have a voice. When you have a David and a Goliath you need an intermediary and …restorative justice is an empathetic, nurturing way forward." (IP13)*

Respondents greatly appreciated the procedural adaptations made during the Listening and Understanding phase of the project in response to the needs of consumers, responsible parties, and facilitators. A key adaptation was the involvement of ACC and professional groups after they were identified as responsible parties in the first few Listening Circles. Other adaptations included proactively contacting some people after the Circles had occurred to provide emotional support and offering a range of mediums to capture stories.

Most consumers indicated that the options of participating in a Listening Circle, private meeting or contributing to the story database allowed them to tell their story in a way that worked best for them (Figure 3). Some felt compelled to tell their story in person to the responsible parties and travelled considerable distances to do so, despite concerns about the impacts on their physical and mental wellbeing.

Figure 3: Options allowed me to tell my story in a way that worked for me

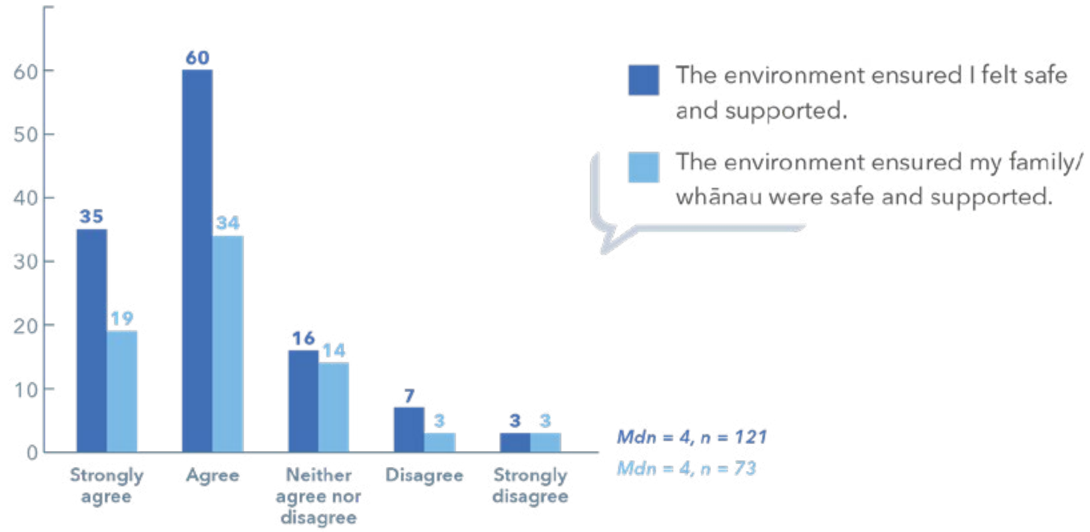


Most people (Mdn = 4) found the story database easy to use. Comments indicate that writing about experiences was cathartic, allowed adequate time for reflection and ensured that practical help and emotional support from family or whānau was readily available. The opportunity to provide a full written account and supplementary information after attending a Listening Circle was welcomed. Consumers also welcomed being able to upload documents, artwork, medical reports, agency documents, and photos of injuries or mesh that had been surgically removed.

Most consumers felt that the information provided by the Victoria University team beforehand prepared them well to attend a Listening Circle or private meeting (Mdn = 4). The MDU Facebook page was also described as a valuable community resource for preparation tips whilst reassuring people that the Listening Circles were a safe experience. However, both consumers and interview participants indicated it was not possible to be fully prepared for the extent of human suffering they heard.

Consumers experienced the Listening Circle environment to be safe and supportive (Figure 4). Comments indicated appreciation for the effort taken to account for the physical needs of mesh injured people. Many described the Circle process as dignifying, equitable, validating and cathartic.

Figure 4: The environment was safe and supportive



The experiences of consumers who had private meetings were consistent with those who attended Listening Circles. On the other hand, private meetings were resource and time intensive and the severity or complexity of their injury or the location of the meeting (for example, in a hospital) posed challenges.

The process used to decide who was prioritised for a private meeting was raised as a concern by a small number of consumers. They would have preferred a private meeting and indicated that listening to the stories of other consumers contributed to them feeling alone, drained, angry or traumatised. In some cases, the freedom to speak frankly was inhibited by the presence of men.

There were multiple survey and interview comments that indicated the physical, psychological, and procedural impacts of surgical mesh harm had been understood in the Listening Circles. The uninterrupted accounts which people shared provided a rich understanding of individual needs, as well as exposing systemic health sector issues:

> *"ACC may have got a claim for a treatment injury, but that's a paper exercise. There is no face, no passion and no emotion attached. People who are one step removed from patients would have indeed got a lot out of [the Listening Circles] by way of understanding and recognising that it's not just a paper exercise, it's a major impact on [someone's] life."* (RP6)

Responsible parties who attended the Listening Circles were profoundly impacted and, even a year later, were able to recall individual accounts in detail. The expectation to sit and listen without responding defensively enabled them to connect at both emotional and intellectual levels. They also indicated a preference for the relational nature of a restorative approach over existing legal or rules-based approaches. They were critical of the adversarial nature of traditional investigations that work to build a case with a particular outcome in mind. Contrary to their intent, they seemed to prevent the conversations necessary for safety improvement:

> *"I am definitely a convert to the restorative approach. I think even more so just from this, but also from personal and other professional experiences.… While this process has not been perfect, I feel like it is miles better and I think that other adversarial ones …. I do not think either party often wins with that."* (RP1)

The honesty and vulnerability that people displayed in Listening Circles evoked feelings of empathy. Many consumers and responsible people stories said that storytelling was dignifying because people were seen and heard as though they mattered:

> *"It was heart-breaking to hear how people's lives have been so thoroughly destroyed in every way you can imagine. I guess the really moving part about it is despite all of that they were coming along to talk to us in a very clear-minded and often fair-minded way. One of the most moving things for me, was that for everything that had been destroyed, people's humanity was still intact."* (RP5)

Figures 5 and 6 show that most consumers felt heard and supported by the facilitators (Mdn = 4), the emotional support person (Mdn = 4) and the responsible parties (Mdn = 4). Feeling heard and supported by responsible parties was statistically associated with a sense that the public were now more aware of the risks associated with surgical mesh. Feeling heard by responsible parties was also associated with confidence during and immediately after the listening process that the actions committed to would lead to safer healthcare in the future.†† Factors associated with feeling heard and supported included feeling welcomed, cared for and shown empathy or validation. The support demonstrated by the responsible parties came as a surprise for this consumer:

> *"I was really surprised that the Ministry of Health representatives were so engaged and supportive. I had not expected that – I guess I thought they would be superior, unfeeling and defensive. The opposite was the case... They were exactly the right people for the job."* (C77)

Figure 5: I felt heard during the Listening and Understanding phase

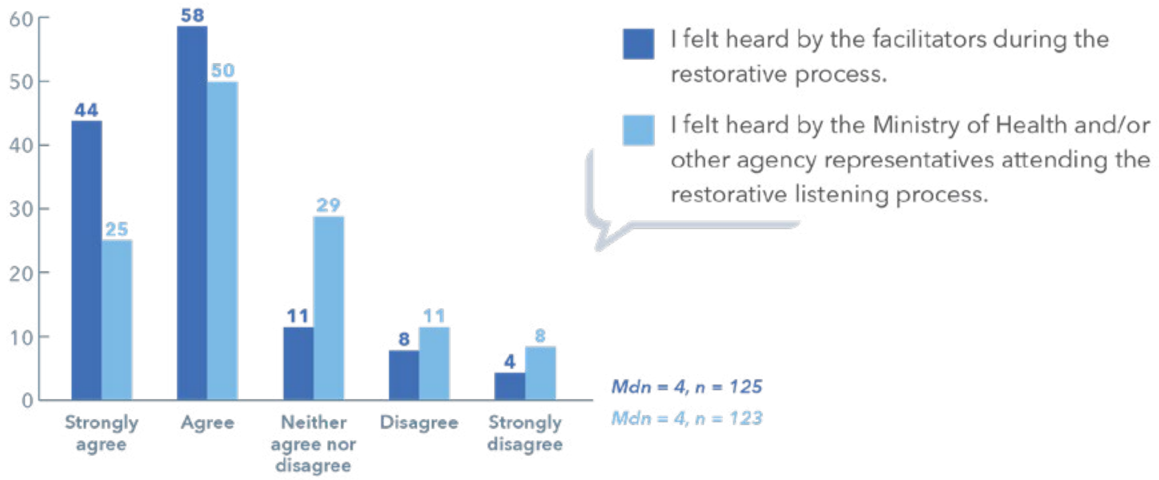
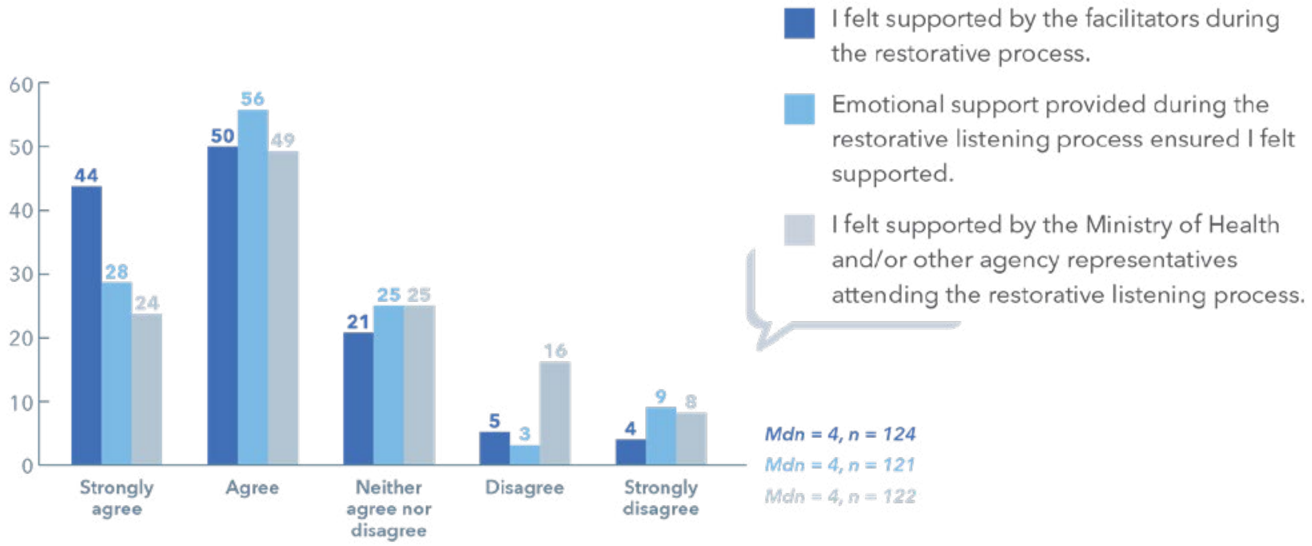


Figure 6: I felt supported during the Listening and Understanding phase



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†† These variables were tested using chi-square tests which show statistically significant relationships. See appendix 5 for details of the tests.

Consumers found the support offered by other mesh injured people to be particularly responsive (Mdn = 4). Being with other consumers harmed by mesh provided a unique feeling of kinship and validation produced from a shared experience:

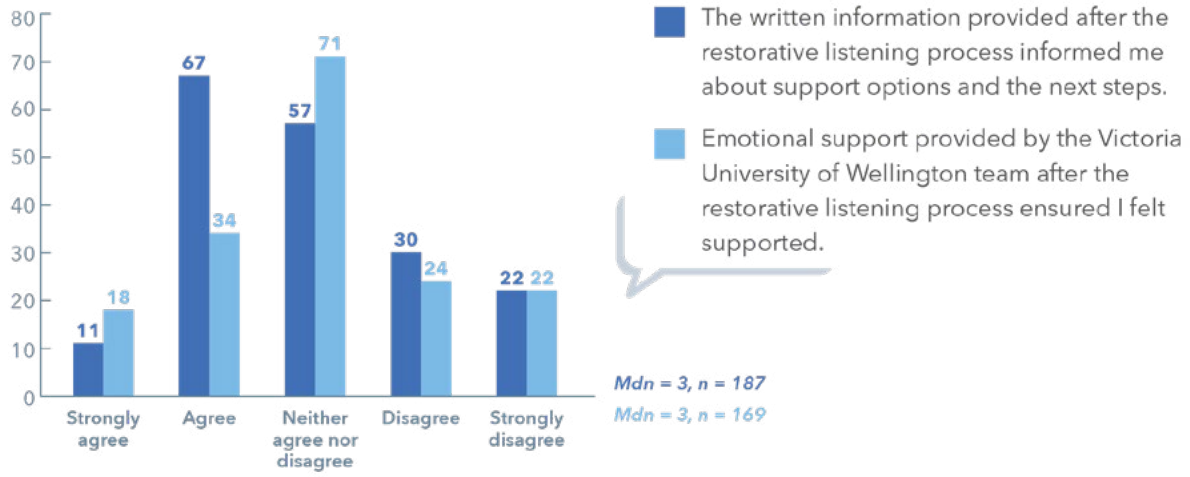
> *"It was nice to be able to be seen as well as listened to, and be able to tell my story without any judgement and have the support of fellow mesh sufferers there to help each other as we all knew exactly what each of us was going through."* (C175)

Many respondents commented on their involvement in mesh support or advocacy groups, particularly MDU, and that joining with other mesh injured people was important to create change. Prior involvement with advocacy groups might explain why most respondents did not access additional support after the Listening Circles (Mdn = 3). Those who did were more likely to be female (n = 23) than male (n = 5). The need for additional support for families was also identified.

What could be improved?

Written resources provided after a Circle, meeting or database submission did not always meet people's needs (Figure 7). Consumers did not welcome being referred back to agencies that had compounded their harm. They had remarkably diverse needs for emotional and follow-up support. Some did not want support at all; others wanted to know about support services available should they be needed in the future; and a small group of people wanted access to intensive support.

Figure 7: Written information and emotional support after the listening process



Consumers seeking intensive psychological support indicated their needs related to alcohol abuse, PTSD, depression or suicidal ideation. Several consumers described the ideal approach as a bespoke follow-up service, aligned with the requested mesh clinic services captured in the surgical mesh project report[1]. Some consumers indicated that storytelling could trigger trauma and suggested a personal follow-up call was necessary:

> *"There should have been personal follow up, not only after the session that night but in the weeks following. Many of us have been suffering for years and this opened a can of emotions that had been trapped for years. My feeling was that many raw emotions had been awoken and the triggers went on for months."* (C48)

The Victoria University team and those representing responsible parties said that attending multiple Listening Circles in a short space of time, whilst attending to everyday work commitments, was unsustainable and contributed to burnout. Adaptations made during the project that supported their wellbeing included longer breaks between Circles and the addition of team members and responsible parties. Representatives of a responsible party found that expressions of anger, distress or trauma meant that it was not an easy role to fulfil. One interviewee found it was a depersonalising experience:

> *"People depersonalised the person they're being vitriolic to, which doesn't depersonalise it while you're listening to them. That was really hard. You're sort of sitting there, sort of being hated actually."* (RP2)

The impacts

Consumers were undecided as to the success of the Planning and Acting phase of the project, evidenced by lower median scores for impact related questions (Mdn = 3). Whilst many consumers indicated that the Listening and Understanding phase had led to renewed confidence in the Ministry of Health and other agencies, they wanted faster action. Implementation of the 19 actions the responsible parties had committed to would be evidence of their accountability:

> *"[The restorative approach has] shown several agencies just how consumers experience their service and how it needs to be improved. The restorative process will certainly improve healthcare safety in the future if agencies know that they will be held to account through such a process."* (C183)

Responsible parties were pleased about the increased pace of change and the collaborative endeavours that had arisen from the process. Prior to the project, agencies seemed to work in isolation due to funding or other incentives. A restorative approach provided important tools that created the conditions for responsible parties to work as a team with a shared purpose. The impact mesh harm has on an individual remained fresh in their minds.

> *"I think this whole experience has demonstrated the value of the restorative process and the engagement of all parties to gain a greater appreciation of how harm has impacted on patients and families… If we didn't have this time and ability to [look at the impact factors] I don't think you would have got the buy-in and the commitment from the parties involved."* (RP8)

What worked well?

A lesson that responsible parties learned from participating in the project was the importance of reciprocity, mutuality, and transparency. These values stood in contrast to common working practices in healthcare described as fragmented, hierarchical, and preoccupied with reputational risk.

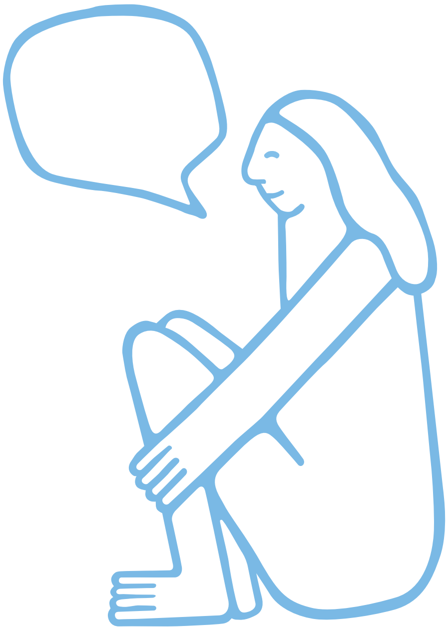
The project report was largely thought to be a valued public record of consumer's experiences and provider responses.[1] Many consumers indicated how they recognised themselves in the stories and welcomed transparency in the public domain:

> *"[The report] vindicated and validated all the stories told on various platforms before, during and after the restorative process into one document."* (IP1)

The report was described as a tool that could engage a broad audience of consumers, agencies, and professional groups. Consumers were pleased the responsible parties had publicly committed to the actions.
The actions detailed in the report provided the foundations for a complex and detailed response that is ongoing. Two people indicated that they had received a written apology from a doctor following the publication of the report.

The use of restorative and ritual practices in the workshop, such as the use of the stones to depict the weight of the stories of suffering, had a lasting impact on responsible parties. They experienced shame about how their agency was letting down their fellow New Zealanders. Hearing people's stories was also a powerful motivator for collaborative action:

> *"You have more goodwill and a lot more buy in and collaboration. Previously you might be seen to be saying "We're going to do this," and dragging your partners along to get it done. Now our partners are trying to drive us faster than we can go."* (RP2)

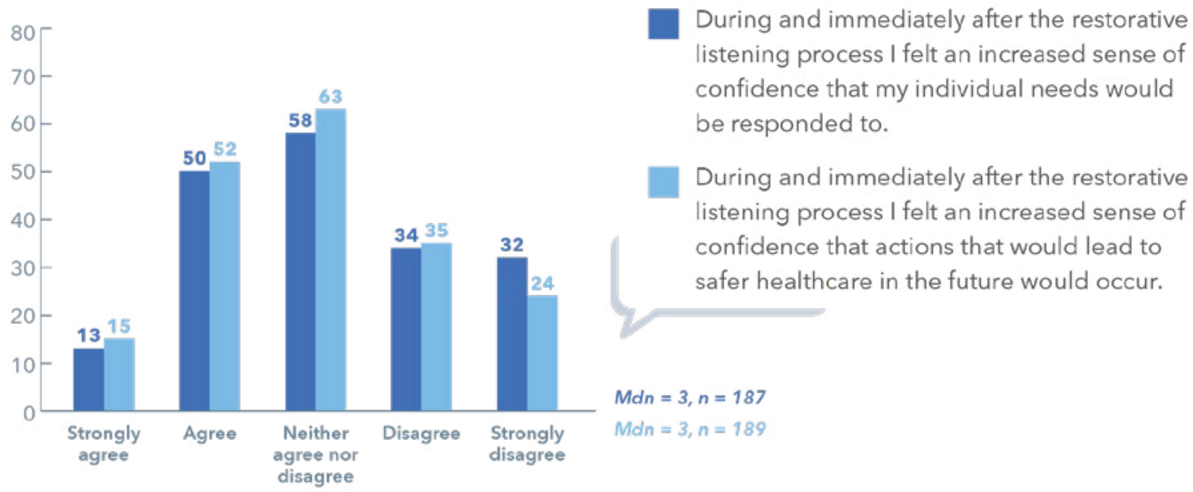


What could be improved?

While respondents understood the impact of the COVID-19 pandemic on the delivery of promised actions, patience was waning. During and after a restorative process many consumers described feeling hopeful, while others were sceptical that their substantive needs would be met or that healthcare would be safer in the future (Figure 8). Most consumers were unsure if their individual situation would change and were undecided as to whether agencies would perform better in the future (Mdn = 3):

> *"Many of my responses to this survey were "neither agree nor disagree". The reason is that until there is a conclusion to the restorative process, I cannot respond with confidence. In the Listening Circle that I attended, the conveners were exceptionally supportive and genuinely concerned for the victim's situations. However, although I have been emailed progress reports, [I am still] awaiting a conclusion/resolution."* (C29)

Figure 8: Increased confidence that individual needs would be met, and actions would lead to safer healthcare in the future



The data indicates that consumers do not think these actions provide adequate psychological support or compensation and lack a formal apology. Those who were not confident during and immediately after the listening process that their individual needs would be responded to remained unsure that:

- the responsible parties would work together to restore the well-being of New Zealanders harmed by mesh
- resources would be allocated to make safety improvements
- there was a commitment to safer healthcare in the future.††

Whilst consumers were pleased their needs were at the heart of the response, several commented on the existing safety culture described in the report and were concerned that safe healthcare would not be realised until these matters were addressed. Several interviewees proposed that restoring and maintaining trust requires an attitudinal shift towards co-design of services where consumers are involved in the creation of public policies and processes:

> *"We are not just listening to the Surgeons; we are actually going to listen to the people who received the services that they provided."* (RP7)

Interviewees reported that doctors are discouraged from admitting their fallibility and that public messaging around patient safety fails to acknowledge that harm to some degree is inevitable in healthcare settings. Some suggested these factors prevented transparent collegial discussion about harm because of the perceived risk to reputation:

> *"It is often easier if there is an out, to blame the product and not have to deal with the dissonance of [causing harm to a patient]. It is very difficult to change that group mentality. To break away from the group mentality, you would be singled out and marginalised. Even if deep inside you thought there was a problem and you voice that, you would become the outsider of the group."* (RP3)

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†† These variables were tested using chi-square tests which show statistically significant relationships. See appendix 5 for details of the tests.

There are considerable emotional impacts on a health professional who has caused harm to a patient. The culture of the medical profession does not support talking openly about these human impacts:

> *"You can't ask for help, can you? You just cannot. There is a disturbing suicide rate as well. So, I think we could do better for doctors."* (RP4)

Many consumers stressed that activism would continue to be necessary. Even with the knowledge about how to navigate the system and armed with diligently researched evidence, consumers still felt they had limited agency:

> *"[Mesh] is a particularly horrific symptom of a larger problem of general lack of respect for patient intelligence and agency within the health system."* (C157)

Advocacy work on the part of the mesh injured was described as exhausting and vicariously traumatising. Interview participants were concerned about the impact of advocacy on consumers but were aware it was an important enabler for change. Persistent criticism about the slow speed of change ironically reduced the capacity of the responsible parties to act quickly, because their energy was diverted into a reactive, and sometimes adversarial, stance.

Responsible parties were aware that the overall level of trust was tenuous and there was much riding on the timely delivery of the 19 actions. Consumers and responsible parties alike commented on the barriers to restoring trust and relationships that were created by bureaucracy, conservatism, reputational risk, the traditional healthcare hierarchies, incivility, and disrespect. They saw the relational characteristics that had contributed to positive experiences of the process – such as being respectful, transparent, distributing leadership and taking responsibility – as enablers of change.

Interview participants suggested more time was required for Planning and Acting and internal agency discussion. The format of the workshop and independent facilitation were well received by the majority, though some felt that the use of small group work limited the time available for consensus building.

The first action detailed in the public report was that the *severity of the harm from surgical mesh use should be publicly acknowledged by the responsible parties*. At least six different organisations issued press releases on the day the report was published that acknowledged the harm (see appendix 7). It is possible that duplication of the messages and publication of the report at the time of the volcanic eruption at Whakaari/White Island may have diluted the impact and reach of these acknowledgements (Figures 9 and 10).

Figure 9: Public acknowledgement of severity of harm and increased public awareness of who is responsible for repair

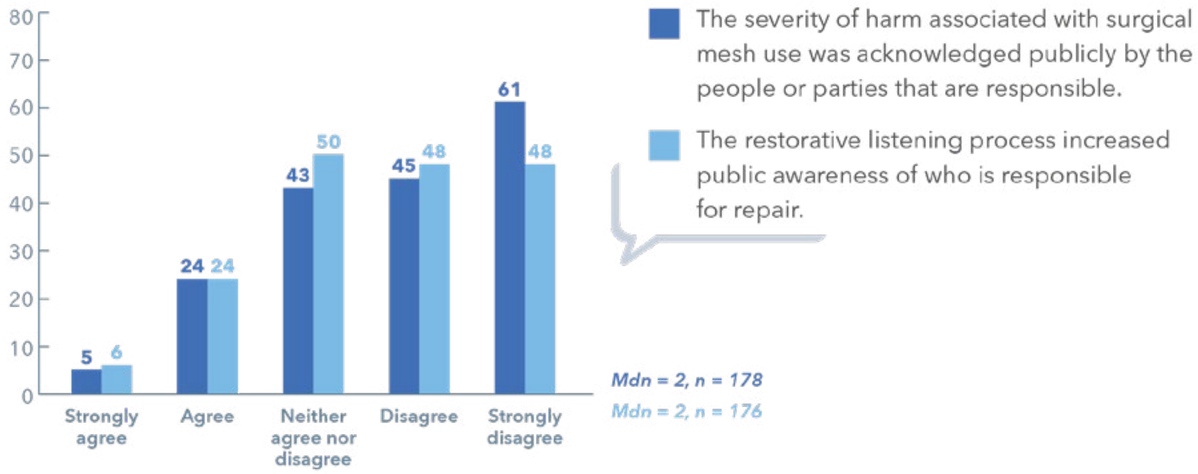
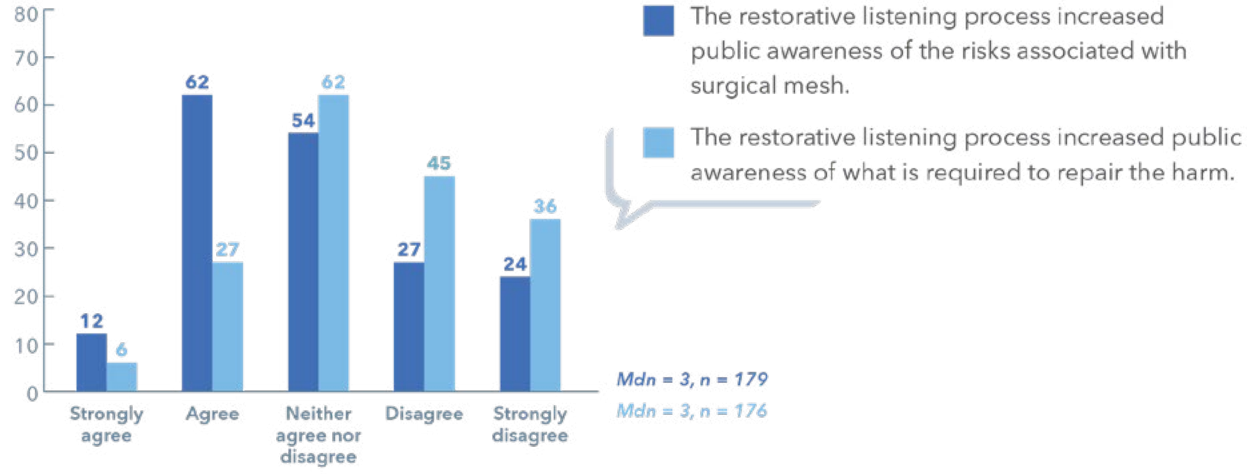


Figure 10: Process increased public awareness of risks and what is required to repair harm



Public awareness of surgical mesh harm has therefore not yet been realised in a manner that satisfies consumers (Mdn = 2). The data indicate that consumers were unaware of updates and statements made during the mesh response. A coordinated communication plan designed by consumer advocates and responsible parties that includes a range of strategies for engagement might address this need in the future. Consumers wanted official communications to avoid *"practised, distancing language"* (C131). Dissonance between the responsible parties' personal values and the messages they were expected to support in official communications led to feelings of distress:

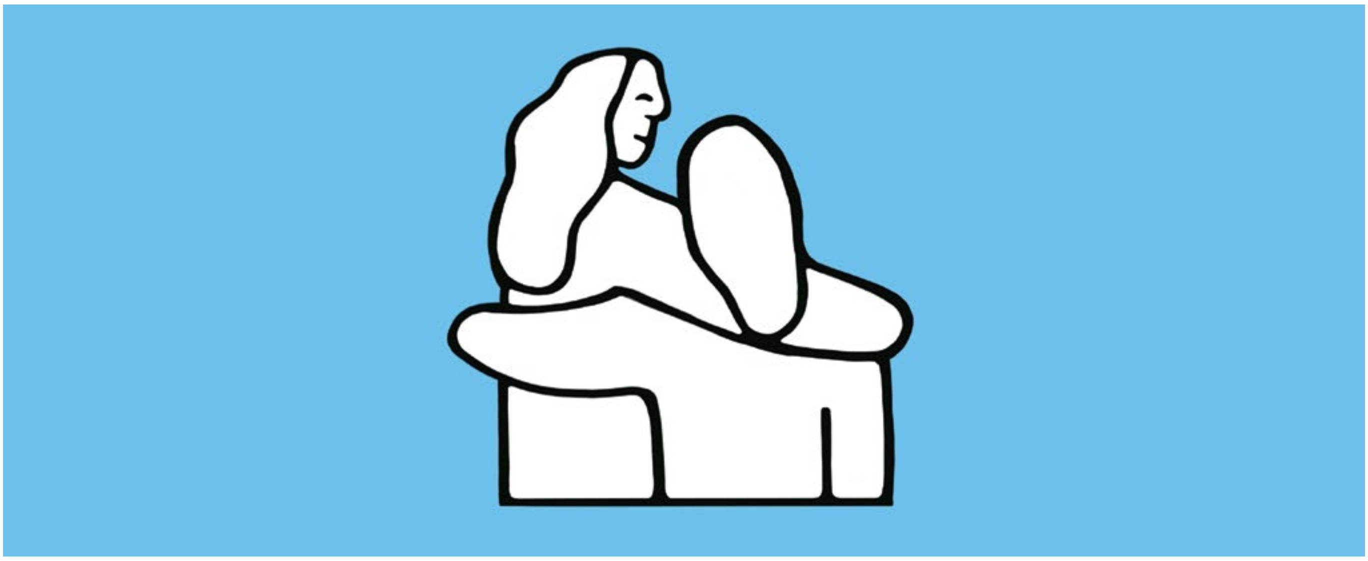
> *"Trying to wear different hats isn't the right way to go; you can't really wear different hats, you're wearing them all at the same time. That is where I ran into trouble, because I could never not be [my official role]."* (RP1)

Many people felt that first step towards reconciliation and repair of trust was for a collective apology to be issued both for the harm experienced from surgical mesh use and the procedural responses that ensued. A ministerial apology, similar to those provided in the United Kingdom and Australia, was considered important:

> *"A credible and senior member of the Government needs to apologise. They need to say we acknowledge that this has not gone well, and we are sorry for the outcome and we expect things to be worked out and done better. It's gravitas isn't it? It's setting that expectation and means that people can't just let it slip and slide."* (RP7)

Some consumers wanted an apology from specific parties, such as ACC, HDC, Johnson & Johnson or their treating doctor. Yet a meaningful apology must also be accompanied by delivery of the 19 actions. Responsible parties said that delivery of all these commitments would take time because of the complex, fragmented nature of the health system, and they were concerned about managing expectations of consumers due to the timeframe required for implementation.

Many consumers were unaware that the Mesh Round Table is responsible for ensuring that the agreed actions are delivered. They wanted a formal independent advocate who would champion consumers rights to be appointed to the group. Existing consumer advocates have insufficient agency to influence the necessary changes. While the HDC could be well placed to take on the advocacy role, consumers felt abandoned by the Commission's withdrawal from the Mesh Round Table.



Should we use restorative approaches in the health context?

A small number of consumers continued to express the desire for disciplinary action against their treating doctor. Many wanted the opportunity to meet their doctor in person, hopeful their experience would be validated by them and they would receive an appropriate apology. Restorative meetings between clinicians and consumers were seen potentially to provide the opportunity for personal and systemic learning that could improve safety culture and practice:

> *"To enable the transformational and systemic change that is needed, I believe the restorative process should be continued in the short term for all surgeons in NZ undertaking mesh surgery. The knowledge gained from going through this process cannot be replicated from reading a report, and I feel it is the best solution for ensuring a genuine change in safety culture and practice."* (IP2)

Responsible parties preferred a restorative process to an enforcement approach. They thought the emotional impacts involved are a necessary part of addressing the problem and could be mitigated. Current safety investigations are overly focused on causation and evidence gathering, to the detriment of understanding and responding to the human experience:

> *"We get the HDC and the Coronial reports … and when you read back… you think, oh goodness! You can see what was important to the patients wasn't necessarily what people were focusing on because initially our focus is on the event itself and to stop it happening again."* (RP9)

Both consumers and responsible parties favoured the relational nature of a restorative approach that brings people together over adversarial approaches that keeps them apart. Both regarded their relationship as interdependent, requiring mutual trust and a shared sense of purpose. Both thought a restorative approach had potential in other situations of healthcare harm because accepting collective responsibility for the systemic conditions that contribute to a harmful event is usually necessary for addressing the harm:

> *"We have moved on from [being] judgemental and trying to make an individual accountable, to understanding the human factors, process issues and the systems that are in place… [A restorative approach] is being able to engage those that were part of the situation that occurred and not cutting the person out and just having somebody front it. (RP8)*

The key areas in which a restorative approach was thought to be potentially transferable included interpersonal conflict resolution, responding to adverse events, and dealing with treatment injuries and consumer complaints.

The potential for extending the reach of restorative approaches

Healthcare systems are increasingly understood to be complex and adaptive, comprising uncertain, dynamic and unpredictable conditions.[14] These conditions have often inhibited international safety efforts over the past 20 years from successfully reducing the incidence of harm.[15] Furthermore, official inquiries into healthcare harm, which usually follow a traditional approach predicated on rules, regulations and investigation by a designated expert, nearly always highlight the devastating impacts of the experience on individuals, families, communities and entities.[16,17,18,19]

It is becoming increasingly obvious there is a need to humanise how health systems respond to harm. The surgical mesh story globally reveals that conventional investigative responses do not meet individual needs and can indeed compound the harm for many people.[1,20] Problems with an over reliance on retrospective analysis of written documents and expert opinion are well established.[21] While restorative inquiry has occasionally been used to address institutional harm,[22] the surgical mesh project in New Zealand appears to be the first case of its use on a national scale within the health context.

This evaluation has found that a combination of proactive and reactive restorative approaches can assist in meeting the substantive, psychological and procedural needs of many participants. Importantly, these practices are potentially transferable to other contexts, as long as critical success factors are met (Table 4). The adaptable character of the practices and their sustained focus on humanistic principles, values and goals are key strengths and are known to be valued by safety leaders in New Zealand.[23]

Storytelling, which lies at the heart of restorative practice, is also an established method for enhancing system safety because it allows a nuanced understanding of events.[24,25] A lesson from the mesh project is that being able to choose how, when, how often and to whom a story of a harmful event is told is essential to humanise the experience of harm.

The recent Health and Disability System Review concluded that a person-centred approach should be central to the New Zealand health system.[26] A restorative approach is person-centred and is likely to be welcomed in other healthcare contexts because consumers and responsible parties alike value the emphasis on dignity, respect, transparency, and equity.

It appears, then, that cultivating a restorative culture in health organisations would have considerable social and economic benefits and encourage a positive safety culture in which people feel safe to raise and respond to concerns.[27] However, providing opportunities for consumers and health providers to meet after a harmful event are often resisted, frequently because of legal or reputational concerns.[28,29] This makes careful preparation and the provision of ongoing psychological support for all the parties involved all the more important.

New Zealand's distinctive ACC legislation is often praised internationally for enabling blame-free investigations, increased consumer involvement and a reduction in the practice of defensive medicine.[30] However, the extent to which this is true is open to question[31] and recent government inquiries have illustrated that the Code of Rights has not empowered consumers to the extent desired.[1,32] Critics allege a medical and legal elite limits consumer voice and the independent assessment of harm.[31,33] This evaluation shows that collaborative efforts and distributed leadership between agencies, advocacy groups and communities are critical to achieving the lofty ideals undergirding the legislation.

Table 4: Critical success factors participants identified

	CRITICAL SUCCESS FACTORS
Collaboration	Use of restorative practices to establish group norms and values at the outset in design process. Co-create the approach with all affected parties and adapt membership as additional responsible parties are identified. Distribute leadership and adapt the approach to meet needs as they emerge.
Restorative Culture	It is safe for responsible parties to speak openly and truthfully about their involvement in an adverse event, which is usually defined as being unexpected, unintended, and unplanned.
Storytelling	Multiple options and opportunities for storytelling. Equity of access e.g. transparent triage criterion for private meetings, location of meetings. Consider offering Circles tailored to specific groups, e.g. female/male only.
Listening Circles	Use of independent and skilled facilitators. Mixed mediums for preparation and follow up emotional support i.e. telephone, zoom or in person, as well as written and website-based information. Ask participants what they need to create a safe and supportive environment during the preparation phase. Use of a restorative inquiry framework. Compassionate, human responses of responsible parties in Listening Circles. Post-Circle debriefing opportunities for consumers and the delivery team.
Emotional support	Consumers to have access to: 1. Emotional support from support people and/or professionals during the process. 2. Psycho-social support after storytelling if needed. 3. Support from community groups and sources (e.g. the MDU Facebook page and the support of other harmed consumers). 4. Someone who can help meet their substantive needs. Delivery team and representatives of responsible parties to have access to: 5. Professional supervision or psychological support. 6. Resources to create capacity in the delivery team i.e. additional facilitators/ representatives.
Adaptation	Continuous procedural adaptation to meet emerging needs, whilst remaining focussed on restorative values, principles, and goals.
Tiriti o Waitangi	Support a Te ao Māori approach and include cultural experts to determine how the needs of Māori are met. Collect ethnicity and demographic data at the outset to determine the geographical and ethnic makeup of potential participants.
Communication	Coordinate public communications across the responsible parties, ideally involving multiple strategies and mediums (e.g. video, social media newspapers, TV, websites). Clearly communicate who is responsible for ensuring actions are delivered by all the agencies, when and how people will be updated. Communicate regularly throughout each phase of the process. Avoid practiced and distancing language and instead speak openly and from the heart.

Responding	Allow enough time for Listening and Understanding and Planning and Acting phases. Identify SMART actions: those that are specific, measurable, achievable, realistic, and timely. Identify the governance approach at the outset, whilst making people aware that group membership may be adapted in response to emergent needs. Collaborate and integrate to coordinate a system wide response.
Take responsibility	Focus on collective responsibility. An apology characterised by an admission of collective responsibility for the conditions that contributed to the harm, and swift action for repair and prevention. Access to a restorative meeting with individual doctors where requested. Access to an independent advocate if a formal complaint is desired.

In the aftermath of the mesh project, ongoing collective action is required to prevent compounded harm when adverse events occur. Compounded harm arises when there is a failure by a responsible party to give account to an affected party for harm that occurs during the provision of care. Meeting the substantive needs of individuals, such as through the delivery of specialist mesh services, remains a priority. Consideration as to how to meet the yet to be addressed needs of apology, compensation and psychological support is also required.

Healing after harm is possible when it is approached within a relational framework and this should be utilised alongside existing regulatory structures. There remains a larger research question to explore to identify the mechanisms that enable the success of a restorative approach in the context of the New Zealand health system if it's demonstrated potential is to be realised on a larger scale.[34]

Tiriti o Waitangi

In Aotearoa, the Crown has an obligation to uphold Te Tiriti o Waitangi. The low numbers of Māori consumers in the mesh project suggests there may be unmet cultural needs. One possible explanation is that because surgical mesh is predominantly used in private practice, it has not been commonly accessed by Māori due to socioeconomic or cultural factors. Another possibility is that Māori consumers did not feel able to raise concerns about their health provider in a context where they are already inadequately supported and served.[35]

It is worth noting that Māori do not report positive experiences of current harm responses.[36] There is reason to believe a restorative approach may be more successful, because it resonates with the relational values of Te ao Māori and Tikanga Māori.[37] Similar to Circle practices, Wānanga Hui (educational seminars) allow different perspectives to be expressed in a safe and respectful way, are mana-enhancing for all involved and have collective wellbeing at their core.[38] Uplifting mana is particularly important for tangata whenua and is necessary to reduce whakamā (shame).[39] Consultation with cultural experts is required to determine if a restorative approach would be welcomed by Māori consumers.

Strengths and limitations

A key strength of this study is its participatory approach to study design and the development of data collection tools, which are consistent with a restorative approach. The use of a consensus group to test findings also enhanced its rigour.

The study is limited by its focus on a process and impact evaluation; it does not address longer term outcomes. The results of the impact evaluation should be also interpreted within the constraints imposed by COVID-19, which caused additional delays. For example, it was only after data collection for this evaluation had ceased that ACC publicly acknowledged the severity of harm from surgical mesh and apologised for compounding the harm through its claims process. Due to the low number of survey responses, further research is required to access the potential of a restorative approach is appropriate for health professionals and Māori consumers. Evaluating what works, how and for whom in different healthcare settings will also be required.

Conclusion

The process evaluation has found that that the Listening and Understanding phase of the mesh project significantly met the psychological and procedural needs of the participants. The massive extent of the harm caused by surgical mesh was powerfully communicated, and the responsible parties were inspired to collaborate and undertake actions for repair and prevention.

However, the evaluation also found that consumers were largely unaware of any progress that had been made on the 19 actions agreed to at the Planning and Acting phase of the project and wanted a swifter response. For these reasons, many consumers were unsure if their substantive needs would eventually be met or if safer healthcare would occur in the future. Meeting the individual substantive needs of mesh injured consumers is essential to restore wellbeing. The offering of an apology and provision of compensation and psychological support are vital to prevent compounded harm and restore relationships and trust.

Healing after harm is possible when it is located within a relational framework and such an option should be provided alongside existing regulatory structures, policies, and procedural responses. Restorative approaches resonate with the relational approach of Te ao Māori and may have more to offer Aotearoa New Zealand than current methods. The Health and Disability System Review provides an opportunity to transform responses to healthcare harm.[26] Further research is required, however, to better understand the mechanisms that could enable the success of a restorative approach to be realised across the context of the Aotearoa New Zealand health system.

Glossary

Adverse event	Events with negative reactions or results that are unintended, unexpected or unplanned.[40]
Affected party	Any person, group or entity affected by harm from surgical mesh.
Chi-square test X^2	A chi-square (X^2) test for independence compares two variables in a contingency table to see if they are related. If the probability value (the *p*-value) is less than or equal to .05, there is a statistically significant relationship between the two variables tested.
Circle process	A Circle process involves structured and intentional conversation which is guided by skilled facilitators. Circle processes typically involve three or more rounds, with the first seeking to connect and build relationships. The following rounds can be proactive, building group norms and shared decision making; or reactive, intending to understand the harm experienced and identify needs. The final round is usually focussed on the future.
Compounded harm	Compounded harm arises when there is a failure by a responsible party to give account to an affected party (such as a consumer or health professional or their family or whānau) for harm that occurs as a result of the provision of care. Compounded harm may be experienced as betrayal, a loss of trust, disempowerment, abandonment and unjustified blame. If compounded harm remains unaddressed, it can grow, spread, evolve and intensify.[§]
Consumer	The mesh injured, their support people, and family or whānau.
Cramer's V Φ_c	Cramer's V (Φ_c) is a statistical test that measures how strongly the two variables in a chi-square test are associated. Where the degrees of freedom in a test are 4 (as they are for all the chi-square tests in this report), a small effect size is .05, a medium effect is .15, and a large effect is .25.
Likert scale (5-point)	A type of response scale in which responders specify their level of agreement to a statement typically in five points: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.
Listening Circle	A Circle process where mesh injured patients and their family or whānau told their story. Representatives of some of the responsible parties were also present.
Mana	Mana is a concept or principle with many shades of meaning including prestige, authority, control, power, influence.[39]
Median	The middle value when a data set is ordered from least to greatest.
Mode	The number that occurs most often in a data set.
Procedural needs	The process of interacting, communicating, and making decisions about how to address the harms.
Psychological needs	The way one is acknowledged, respected, and treated throughout the process, ensuring those affected can honestly communicate differences, concerns and potential similarities with each other in a safe way.

P-value	The threshold set in this report for statistically significant results are *p*-values less than or equal to .05.
Responsible Party	Individuals, groups, or entities identified by the affected parties as having a significant role to play in the occurrence of the harm and in the reparative and preventative actions required as a result of the harm.
Restorative approach	A voluntary, relational process whereby those with a personal stake in a harmful episode come together, in a safe and respectful environment, with the help of skilled facilitators, to speak truthfully about what happened and its impact on their lives; to clarify accountability for the harms that have occurred; and to resolve together how best to promote repair and bring about positive changes for all involved.[2]
Restorative practices	Practices used to enact a restorative approach, e.g. Circles, facilitated meetings, restorative conversations and forms of inquiry.
Restorative response	A collaborative, non-adversarial response to an adverse event or complaint that is characterised by inclusive democratic dialogue, and is guided by concern to address harms, meet needs, restore trust and promote repair or healing for all involved.
Substantive needs	The physical or material harms that need to be remedied.
Tangata whenua	A Māori term that literally means “people of the land”. It can refer to either a specific group of people with historical claims to a district, or more broadly the Māori people as a whole.
Whakamā	A Māori term that refers to a state of personal or collective embarrassment and shame.

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§ Definition developed by Carolyn Canfield, Citizen Patient and Adjunct Professor, Faculty of Medicine, University of British Columbia; Jo Wailling, Research Fellow, Diana Unwin Chair of Restorative Justice, Victoria University of Wellington; Allison Kooijman., Citizen Patient and master’s student (interdisciplinary studies), Faculty of Nursing, University of British Columbia.

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Appendices

Appendix 1: Differences between a restorative and traditional inquiry**

Traditional public Inquiry	Restorative approach
Government or legal authority determines scope, terms of reference	Affected parties (Government, former residents, community partners) work together to design the process
Sole Commissioner (often sitting or retired judge) or small panel selected to lead inquiry	Process guided and overseen by a council of parties (representative of those most affected or connected)
Meetings/hearings are judicial in nature, often held in a courtroom	Meetings held in a flexible variety of settings, from small groups to wider gatherings, depending on need
Process focuses on what happened, when went wrong – "finding blame"	Process examines bigger context: what happened, why it happened, why it matters for the future – understanding responsibility
Proceedings can have an adversarial feel, with "witnesses" enlisting legal counsel for support	Processes take a non-adversarial and participatory approach; participants feel supported and welcomed to give their perspectives
Witnesses can be subpoenaed to appear in a court setting	Subpoenas less important in a collaborative approach where all the parties have a say in the process used only in support of the collaborative process with participants prepared and supported
Commissioner/small panel develops report and recommendations at the end of the Inquiry	All affected parties provide input that helps determine next steps; information developed and shared and actions can be proposed/enacted throughout the process
Commission delivers report and recommendations to Government, with no authority to make change or ensure follow-through	All parties, including decision-makers and community leaders, have a stake and role in developing and following through on recommendations and outcomes; final report shares actions taken with the process as well as plans and commitments for the future
Outcomes typically involve new or updated policies/procedures for public agencies	Outcomes should include improved relationships between agencies and communities, better ways of working together, end result not only actions but a capacity for, and commitment to, sustainable change

** From Canadian Government. (2019). Journey to light: *The final report of the restorative inquiry, Nova Scotia home for colored children*. Nova Scotia, Canada, Crown Copyright. p. 29.

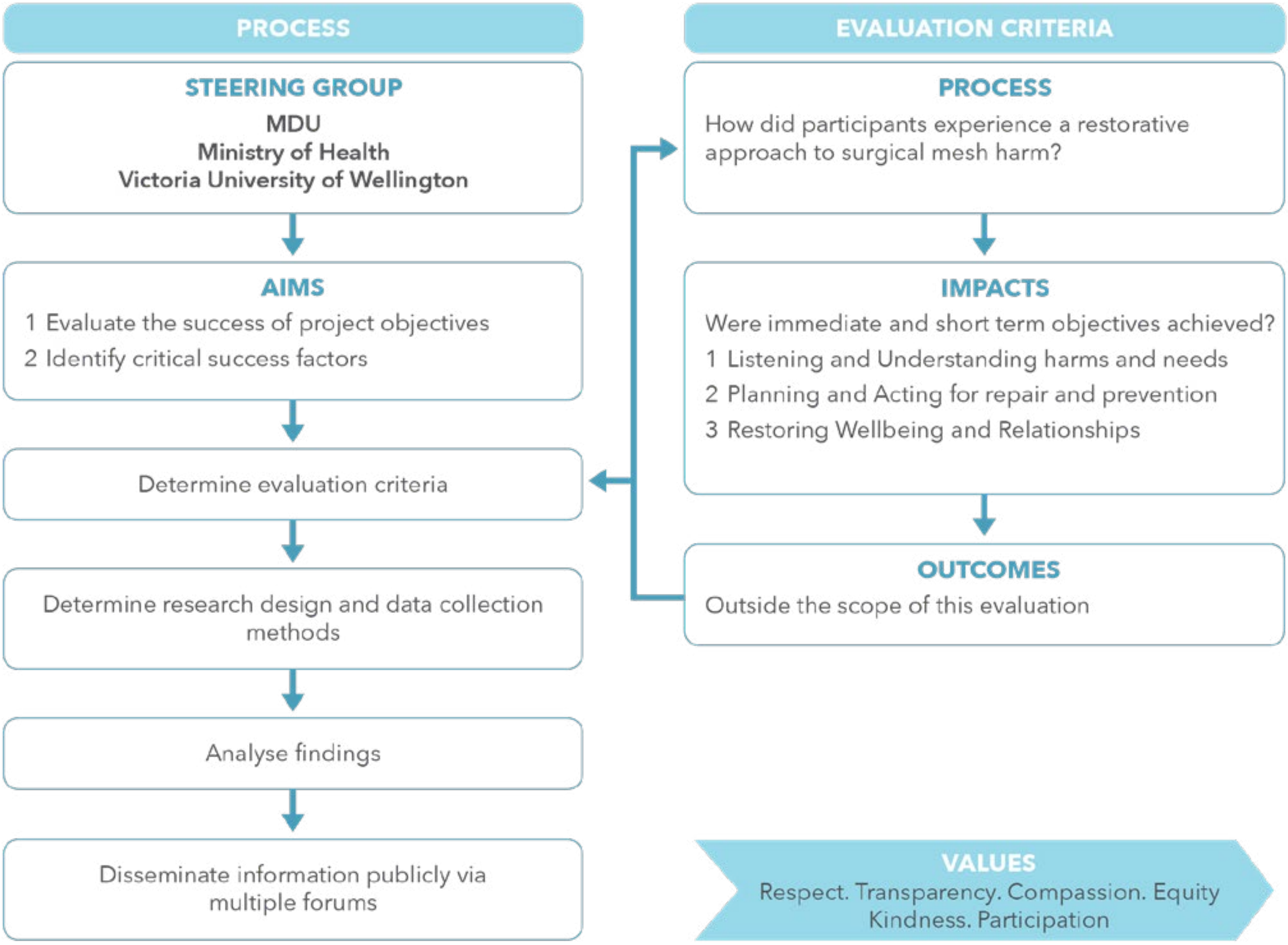
Appendix 2: How restorative principles were applied in the project *'a restorative approach to surgical mesh harm'*

	Restorative principle	Practice examples
Preparation	**Voluntariness**	• Mesh injured consumers were invited to participate via multiple platforms (email/communications in press). • Health professionals were invited to participate via professional bodies and publications. • Representatives of responsible agencies invited to attend a Listening Circle and the Planning and Acting workshop.
	Informed consent and preparation	• Written information about the Listening Circles was shared in advance. A link to the restorative health website was included where detailed information about Listening Circles was available. • Consumers could contact emotional support staff via phone/email before attending a Listening Circle. • Written communication included details of the national 1737 telephone number. • 1737 (national counselling helpline) was briefed on key issues relating to surgical mesh so that tailored 24/7 emotional support was available. • Responsible parties were offered a telephone or face to face meeting with a facilitator before attending the Listening Circle. • A draft report outlining the harms and needs created by mesh was shared with responsible parties before the action planning workshop. • Facilitators met with responsible parties before the workshop. • Project participants were asked to consent to their stories and/comments being captured by a researcher and their identity remained confidential.
	Relational process	• Video of facilitators introducing themselves was posted on the website. • Relationship building between Listening Circle participants before, during and after the Circle (time for tea breaks and debriefing with other mesh injured consumers and responsible parties). • The emotional support, facilitator, researcher and responsible parties participated in the first and closing rounds of the Listening Circle (introduced themselves and reflected on the key themes they had heard).
	Process designed to meet needs of those impacted	• Process was co-designed with consumer advocates, senior representatives from Ministry of Health and the research/facilitation team. • Guiding values for the co-design process were co-created and guided all decisions. • Wide consultation with multiple affected parties. • Travel reimbursement was provided, and consumers were asked to identify any specific comfort/accessibility needs during registration process.

	Restorative principle	Practice examples
Storytelling	**Multiple options**	• Multiple options for consumer storytelling (story database, Listening Circles, private meetings). • Multiple options for healthcare professionals (story database, telephone/zoom interviews). • People could tell their story more than once and in more than one medium. • Multiple mediums could be collected (photos, poems, medical records, letters, artwork, video). • Stories documented in a public report.
	Emotional support	• Support people could attend Listening Circles and private meetings to share how they had been impacted by surgical mesh. • Follow up emotional support from the Victoria University team (via phone/email) was offered to all participants in a follow up email. Written information also included details of the national 1737 telephone number, ACC treatment injury process and HDC complaints information. • Those who indicated a potential risk of self-harm or requested additional support at Listening Circle were provided with referral options at the Circle. A small number of people were also contacted by phone by the emotional support team later that day. • 1737 (national counselling helpline) was briefed on key issues relating to surgical mesh so that tailored 24/7 emotional support was available.
	Flexible process	• Participants could choose the questions they wanted to answer. • Participants did not have a time limit for individual storytelling and could share as much or as little as they wanted to (Circles ranged from 2-5 hours). • Individual sessions accommodated practical and comfort needs (e.g. Travelling to hospitals/private residences).
	Respectful communication	• Listening Circle ground rules were established at the beginning of each Circle and agreed upon by all participants. • A talking piece was used to minimise interruption and ensure conversational turn taking. • Facilitators upheld the ground rules by interjecting when required to reframe, redirect or remind participants of their commitments. If required facilitators supported private conversations to clarify and repair any perceived hurtful comments.
	Safe environment	• Emotional support on site. • Breakout rooms available. • Spaces (mostly hotel/conference rooms) were neutral, easily accessible, and private. • Comfort needs provided (food, coffee, water, accessible and close rest rooms).

	Restorative principle	Practice examples
Storytelling	**Independent skilled facilitation & advice**	• Consultants with expertise in healthcare safety and restorative approaches were included in the co-design process. • Experienced practitioners guided the codesign, preparation, Listening Circles, private meetings, action planning workshops and team debriefing.
	Participants have equal voice	• Use of a *talking piece*. • Circle practices in co-design, Listening Circles and action planning workshop support democratic structure, psychological safety and shared decision making. • Responsible parties asked to listen and reflect back key themes at Listening Circles.
	Those identified as a responsible party are involved in the process	• Representative from health sector agencies identified as responsible parties were invited to participate in Listening Circles to directly hear about the harm experience.
Follow up	**Clarify who is responsible for repair and prevention**	• Responsible parties and consumer advocates participated in an acting and planning workshop which intended to identify individual and shared responsibilities of the multiple agencies involved. • Those who had attended Listening Circles were invited to reflect and share the impact on their agencies and them as individuals. • Workshop content and outcomes documented in a public report.
	Collaborative decision making	• Potential actions were collectively agreed to through consensus. • Each representative led internal decisions within their agency to confirm commitments.
	Outcomes are designed to repair and prevent harm	• Outcomes were specifically identified to repair and prevent harm. • Leadership, governance, and delivery of actions agreed by consensus and confirmed after the meeting.
	Outcomes documented and shared with all parties	• Actions that were committed to following internal agency discussions were documented in the public report. • Public report shared with all project participants by email and published on the Ministry of Health website. • Professional colleges agree to share with their members.

Appendix 3: Research process



Appendix 4: Analysis of peoples hopes and wishes for the process

	Consumers	**Health professionals**	**Health sectors leaders**	**Co-design team**
Themes: Process				
People can tell their stories in a way of their choosing				x
Listening Circles provide a safe and supportive environment for storytelling	x			x
Adequate emotional support is provided throughout the process				x
Appropriate information is provided to participants throughout the storytelling process	x			x
The stories of people impacted by mesh harm are heard by others in the mesh community	x			x
The stories of people impacted by mesh harm are heard by those responsible for repair and prevention	x			x
The severity of the harm caused by mesh is acknowledged by responsible parties attending Listening Circles and meetings	x			x
The need for increased collaboration between health agencies is understood and enacted			x	x
Themes: Impacts (immediate and short term 6-12 months from project initiation)				
Stories are heard and believed (voice, validation, dignity)	x	x	x	x
The needs of the mesh injured, and their families are identified	x	x	x	x
Awareness of the risks of treatment involving mesh is increased and prevents future harm	x	x	x	x
Awareness of the severity of mesh harm is increased in the medical community which leads to safer healthcare delivery	x	x	x	x
Resources are allocated for immediate safety improvements	x	x		x
Needs are understood so that they can be planned for and resourced			x	x
The severity of the harm caused by mesh is acknowledged publicly by the Ministry of Health and other agencies identified as accountable and responsible for repair and prevention	x		x	x
The Ministry of Health and other agencies commit to act swiftly for repair and prevention	x	x	x	x
Themes: Outcomes to be assessed in the long term (not evaluated)				
The health and wellbeing of mesh injured consumers and their families is restored as far as reasonably practicable	x	x	x	x
Harm from surgical mesh use is reduced as far as reasonably practicable	x	x	x	x
Healthcare practitioners working in surgical environments feel safe and supported to raise safety concerns		x		
Therapeutic relationships between medical practitioners and consumers are restored		x		x
The needs identified in the public report are met	x	x	x	x
Restoring public trust in healthcare institutions and practitioners		x	x	x

Appendix 5: Technical details of the quantitative data analysis

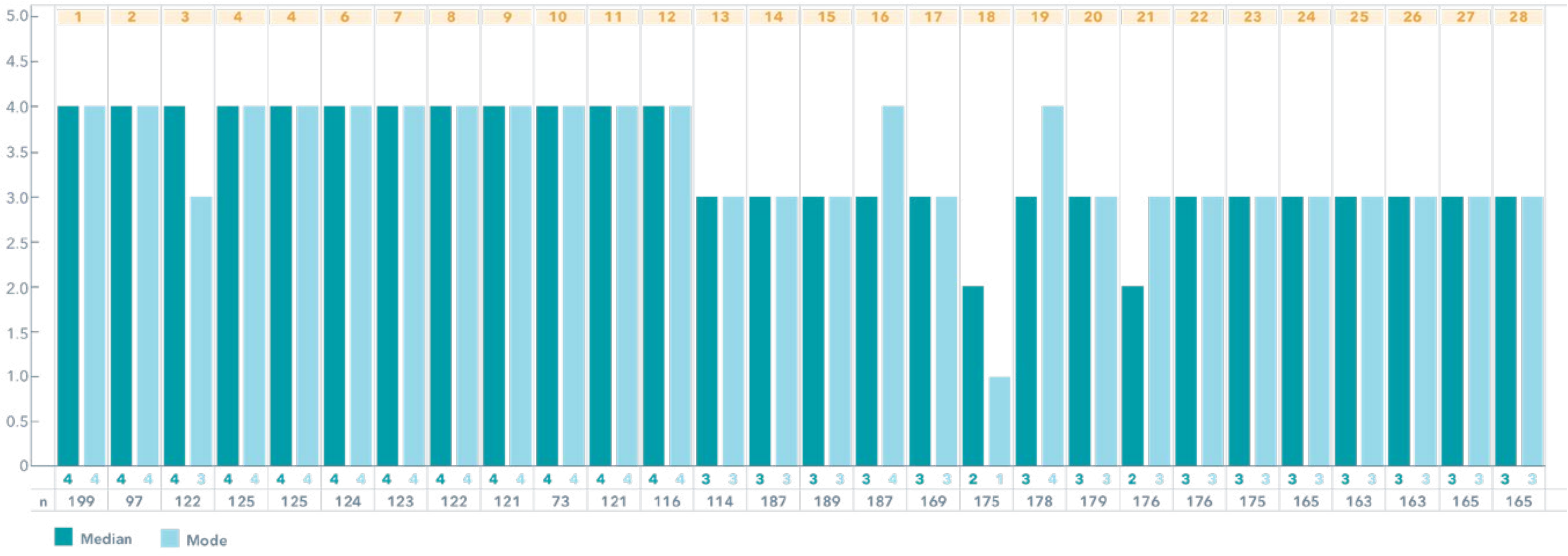
Likert question reponses were analysed as numerical data on a scale of 1 to 5, where 'strongly agree' equals 5, 'agree' equals 4, 'undecided' equals 3, 'disagree' equals 2, and 'strongly disagree' equals 1. These data were then analysed using quantitative data analysis software (SPSS version 26). Descriptions of who participated in the evaluation and the Likert scale responses have been presented using charts and summary statistics (counts, median and mode). The median is the middle value when a data set is ordered from least to greatest; the mode is the number that occurs most often in a dataset. The charts in the report show the range of responses received for individual questions and include the number of responses (n) and the median (Mdn). The chart on page 39 shows the median as well as the mode for all the Likert question responses and includes the wording of each survey question.

Where indicted by the qualitative analysis, statistical tests using the chi-square (X^2) test for independence were used to explore relationships between Likert question responses. A chi-square test compares two variables in a contingency table to see if they are related. If the probability value (the p-value) is less than or equal to .05, there is a statistically significant relationship between the two variables tested. The threshold set in this report for statistically significant results are p-values less than or equal to .05. The tests of relationship between the questions tested are presented on page 40 and also show the effect size or the strength of the relationships using the Cramer's V (Φ_c) statistical test. A small effect size in a Cramer's V test is .05, a medium effect is .15, and a large effect is .25.

Chi-square tests have been reported where expected cell values were not less than 5 and a statistically significant relationship was found (i.e. where $p \leq .05$). Likert categories were collapsed from five to three for these tests (Agree, Undecided, Disagree).

All Likert question responses

1	The options of participating in a facilitated meeting and/ or contributing to the story database (online or by post), allowed me to tell my story in a way that worked best for me
2	The online story database was easy to use
3	Emotional support provided by the Victoria University of Wellington team before the restorative listening process ensured I felt supported
4	The information provided about the restorative listening process adequately prepared me for the meeting
5	I felt heard by the facilitators during the restorative listening process
6	I felt supported by the facilitators during the restorative listening process
7	I felt heard by the Ministry of Health and/or other agency representatives attending the restorative listening process
8	I felt supported by the Ministry of Health and/or other agency representatives attending the restorative listening process
9	The environment ensured I felt safe and supported
10	The environment ensured my family/ whānau were safe and supported
11	Emotional support provided during the restorative listening process ensured I felt supported
12	At the Listening Circle I felt heard and connected to others in the mesh community
13	Following the restorative listening process I have sought support from the mesh community that I had not accessed previously
14	During and immediately after the restorative listening process I felt an increased sense of confidence that my individual needs would be responded to
15	During and immediately after the restorative listening process I felt an increased sense of confidence that actions that would lead to safer healthcare in the future would occur
16	The written information provided after the restorative listening process informed me about support options and the next steps
17	Emotional support provided by the Victoria University of Wellington team after the restorative listening process ensured I felt supported
18	The severity of harm associated with surgical mesh use was acknowledged publicly by the people or parties that are responsible
19	The restorative listening process increased public awareness of the risks associated with surgical mesh
20	The restorative listening process increased public awareness of what is required to repair the harm
21	The restorative listening process increased public awareness of who is responsible for repair
22	I am aware of the actions that all agencies have progressed since the report was released to the public
23	The actions agencies have committed to will adequately meet my individual needs
24	The actions agencies have committed to will adequately meet the needs of mesh injured consumers and their family or whānau
25	The actions agencies have committed to will ensure safer healthcare in the future
26	I am confident that the restorative listening process will ensure that the Ministry of Health and other agencies are committed to working together to restore the well-being of New Zealanders affected by surgical mesh harm
27	I am confident that agencies will allocate the resources required to make safety improvements
28	I am confident that the restorative listening process will ensure that the Ministry of Health and other agencies are committed to ensuring safer healthcare in the future



Tests of association used in the report

	I felt heard by the Ministry of Health and/or other agency representatives attending the restorative listening process	I felt supported by the Ministry of Health and/or other agency representatives attending the restorative listening process	I am confident that the restorative listening process will ensure that the Ministry of Health and other agencies are committed to working together to restore the well-being of New Zealanders affected by surgical mesh harm	I am confident that agencies will allocate the resources required to make safety improvements	I am confident that the restorative listening process will ensure that the Ministry of Health and other agencies are committed to ensuring safer healthcare in the future
During and immediately after the restorative listening process I felt an increased sense of confidence that my individual needs would be responded to			$X^2(4) = 36.530$ $p < .001$ $\Phi c = .36$ $n = 162$	$X^2(4) = 22.171$ $p < .001$ $\Phi c = .261$ $n = 163$	$X^2(4) = 23.532$ $p < .001$ $\Phi c = .269$ $n = 163$
During and immediately after the restorative listening process I felt an increased sense of confidence that actions that would lead to safer healthcare in the future would occur	$X^2(4) = 24.295$ $p < .001$ $\Phi c = .318$ $n = 120$		$X^2(4) = 68.353$ $p < .001$ $\Phi c = .458$ $n = 163$	$X^2(4) = 45.973$ $p < .001$ $\Phi c = .374$ $n = 164$	$X^2(4) = 52.291$ $p < .001$ $\Phi c = .399$ $n = 164$
The restorative listening process increased public awareness of the risks associated with surgical mesh	$X^2(4) = 20.395$ $p < .001$ $\Phi c = .298$ $n = 115$	$X^2(4) = 19.079$ $p < .001$ $\Phi c = .289$ $n = 114$			

Φc = Cramer's V. All indicate an effect size ≥ Cohen's definition of 'large'. Only *p*-values that are statistically significant (≤ .05) have been reported.

Appendix 6: Consensus group members

Name	**Role** **Research Steering Group**
Jo Wailling	Research Fellow The Diana Unwin Chair in Restorative Justice Principal Researcher
Dr Andrew Simpson	Chief Medical Officer Ministry of Health Project Sponsor
Clare Possenniskie	Manager, Office of the Chief Clinical Officers
Margareth Broodkoorn	Chief Nursing Officer, Ministry of Health
Carmel Berry	Consumer advocate, Mesh Down Under
Patricia Sullivan	Consumer advocate, Mesh Down Under
Charlotte Korte	Consumer advocate, Mesh Down Under
	Consensus Group Members
Professor Chris Marshall	The Diana Unwin Chair in Restorative Justice
Professor Joanne Crawford	The WorkSafe Chair in Health and Safety Faculty of Health
Dr Jill Wilkinson	Research Fellow Diana Unwin Chair in Restorative Justice
Dr Tom Noakes-Duncan	Lecturer Diana Unwin Chair in Restorative Justice
Dr Lisa Te Morenga	Senior Lecturer, Maori Health & Nutrition Faculty of Health
Dr Lesley Middleton	Senior Lecturer in Health Policy Faculty of Health
Professor Yvette Tinsley	Professor of Law School of Government
Alex Zuur	Research Fellow & Facilitator Diana Unwin Chair in Restorative Justice
Haley Farrar	Programme Development Advisor & Facilitator Diana Unwin Chair in Restorative Justice
Jacqueline Tuffnell	Consumer Advocate

Appendix 7: Statements of Acknowledgement

Date	Headline	Content	URL	Author
12 Dec 2019	Report highlights severity of harm from surgical mesh	The Ministry of Health has released a report detailing the harm surgical mesh has caused New Zealand men and women: Hearing and Responding to the Stories of Survivors of Surgical Mesh.	https://www.health.govt.nz/news-media/news-items/report-highlights-severity-harm-surgical-mesh	MOH
12 Dec 2019	Surgical mesh restorative justice report received	Media Statement from Hon Julie Anne Genter, Associate Minister of Health	https://www.scoop.co.nz/stories/PA1912/S00102/surgical-mesh-restorative-justice-report-received.htm	Scoop
12 Dec 2019	Hearing the stories of mesh survivors	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) acknowledges the pain and suffering of New Zealand women who have experienced serious complications from pelvic mesh implants. Hearing the stories of survivors through the Victoria University restorative process has been powerful and we are very sorry that the well-intentioned actions of our profession resulted in such harm.	https://ranzcog.edu.au/news/hearing-the-stories-of-mesh-survivors	RANZCOG
12 Dec 2019	Response to release of the public report	The Office of the Health and Disability Commissioner acknowledged the release today of the report detailing the harm caused by surgical mesh and the experiences of those people at the centre of the report.	https://www.hdc.org.nz/news-resources/search-resources/media-releases/response-to-release-of-surgical-mesh-report/	Health & Disability Commissioner
12 Dec 2019	Surgical mesh report: ACC taking action to improve client experience and health outcomes	We're taking a number of actions to improve the experience and health outcomes for people treated with surgical mesh.	https://www.acc.co.nz/newsroom/stories/surgical-mesh-report-acc-taking-action-to-improve-client-experience-and-health-outcomes/	ACC

12 Dec 2019	Response to the release of the public report	The Royal Australasian College of Surgeons (RACS) acknowledges the substantial harm suffered by New Zealand mesh patients and their families and is committed to helping make the changes necessary to improve mesh patients' care.	https://www.surgeons.org/news/media-releases/surgeons-committed-to-improving-mesh-patients-care	RACS
May 2020	May 2020 update	An update on each of the actions detailed in the report is provided below. Unfortunately, and understandably, some resources have been reassigned to respond to the COVID-19 pandemic and this will cause some delays, but we remain committed to delivery of the actions.	https://www.health.govt.nz/our-work/hospitals-and-specialist-care/surgical-mesh/hearing-and-responding-stories-survivors-surgical-mesh-updates/hearing-and-responding-stories-survivors-surgical-mesh-may-2020-update	MOH
August 2020	ugust 2020 update	Activities since the last May 2020 update	https://www.health.govt.nz/our-work/hospitals-and-specialist-care/surgical-mesh/hearing-and-responding-stories-survivors-surgical-mesh-updates/hearing-and-responding-stories-survivors-surgical-mesh-august-2020-update	MOH