Clara Shield:

Welcome to the Practising Mindful Practice podcast series. Practising Mindful Practice is a resource for heritage professionals exploring their working practice around the development of mental health and recovery programmes funded by the Baring Foundation.

Zoe Brown:

The series has been produced by Tyne & Wear Archives & Museums, or TWAM, as we like to call it. I'm Zoe Brown, the outreach officer for the Culture, Health and Communities team.

Clara Shield:

And I'm Clara Shield and I work alongside Zoe as lead for our health and wellbeing programme.

Zoe Brown:

Episode one, Organisational Values and Co-Designing with Agenda Alignment. Episode one will look at a range of thoughts and experiences about developing mental health and addiction recovery sector work within clinical settings and community settings. This will include aspects of setting up projects, relationship building, agenda, aligning, and roles and responsibilities.

Clara Shield:

My name is Clara Shield and I am an assistant outreach officer for Tyne & Wear Archives & Museums Communities team. I'm the programme lead for the Wellbeing programme and currently the majority of my work at the moment is delivering in mental health settings.

Delores O'Doherty:

My name is Dolores O'Doherty. I'm an occupational therapist from Bede Ward, but I work on the acute male ward.

Clara Shield:

So I'm currently delivering a heritage programme at St. Nicholas's Hospital, which is a hospital in Newcastle upon Tyne. It has various wards on site, including an adult forensic, medium and low secure unit, and a variety of wards providing adult urgent care and rehabilitation for adults. So the heritage programme that I'm delivering at the moment is a weekly programme, and we are currently working within a variety of different wards, male and female and mixed wards. And the programme is a collaborative programme that is designed with both the patients, the staff, and myself as the heritage worker.

Delores O'Doherty:

I don't know whether I would say it was a challenge. It was actually a pleasure to be honest, when you came and worked with us, Clara. And I think the big part was having that shared vision and having the same kind of purpose and understanding of what we wanted. I found it quite easy, to be honest, to work with you.

Clara Shield:

The experience that I've had has only been within the St. Nicholas Hospital and Cumbria, Northumberland, Tyne and Wear Trust CNTW. The work that I've been doing to date has meant that the content of what I felt I could offer was originally discussed with occupational health therapy teams that work into and onto the wards. And then there is also the way that that work works within the clinical settings within the wards. So in effect, that's three different approaches to the support in an ongoing recovery of the patients on those wards. At the start of the programme, it was very much around occupational health staff approaching the museum, approaching the team and asking what could we offer. And then us enabling a conversation which was around us discussing the different approaches and experiences we've had working in clinical settings, but also within mental health and also which of our collections work well within those settings.

Once we had established that kind of unified work in an approach, which was, I must say, really easy to do because the links between occupational therapy outcomes and approaches sit really well within the work of our communities team, the occupational health therapists then needed to go and speak to the clinical ward managers just to check and see how this was going to work in practice on the wards. So I guess the key thing is around the communication and recognising what has worked well, what would be good approaches, what needs to be adjusted given the needs of the wards, the patients, and also I guess the agendas of those organisations. So this took quite a little bit of time of discussing because there was, to be quite honest, a bit of inexperience. So just not really knowing what we could offer, what we meant by our collections.

So I think one of the key things around aligning agendas and relationship building is around having commonality of language. So we understand what we are talking about when we talk about our collections, when we talk about patients' needs, when we talk about clinical outcomes, what they actually mean, and having that openness to be able to have truthful conversations around that, around the bits we don't know and where we need to learn. And it has been a lot of learning. So by no means is the work that I've been doing, the kind of perfect approach. There's always things that need to be adjusted and changed, and we are always learning from both healthcare professionals and also from my colleagues within heritage as well, to give advice to the heritage professionals who are thinking about doing some mental health work. What sort of things do they need to think about right at the very start before they even think about the creative workshops they're going to do?

Delores O'Doherty:

I suppose that they've got the right person coming into the ward. To me that is one of the big challenges for them because some people, they may be brilliant at what they do in the museum and the creative industries, but they may not be able to manage being in an acute ward. I'm sure you remember some of the patients can be very challenging. They can be right up to your face, they can be disruptive, they can be quiet, they can be disengaging, but they can be quite manic. So you've got an awful lot to manage while you're trying to present to that group and talk to people. And some people will not be able to manage that, and it might frustrate them. It might get them too anxious, they might not have the same level of confidence, and if they have to come back week after week and do do that, and they're not right person for the job, that's going to show very, very quickly.

And that will make it more difficult for us to work with them if they're looking nervous, anxious, distressed by it, fearful at times, and the patients will pick up on that. So you need to think of the right person for that that can manage that. We know all the risk history, so our staff would be knowing the risk history where we cannot let union be privy to that, but I suppose it would be knowing some of the behaviours that's likely to happen because we'll know whether a patient is to be likely to come up and be talking to you and then slap you, which can happen or can be verbally abusive or patients who don't like to be put on the spot about things, if they're sitting quietly, let them sit quietly. So we might be able to let you know some of the behaviours and the way we help to manage it. So I suppose it's just taking your cue from us. Anybody that's coming in should know that it's not their responsibility to manage the behaviours that is up to the clinical staff. We've got the alarm. So I know when we work with you, there was always a member of staff with you and we had the alarms. I cannot remember if we give you one or not, Clara,

Clara Shield:

I didn't get one on your ward, but I was always with the activity coordinator.

Delores O'Doherty:

And anybody that we bring in for volunteers, we always say, you won't be alone and any behaviours that happen, leave it to us. But I think the level of experience and that obviously shown with yourself, you'd never seem daunted with any of the behaviours at all that happened on the ward. And there was many that happened, and I think that comes back to the right person for that job and it's debriefing. I suppose that's really important. If something upsetting does happen that we're able to talk about that afterwards and see what we can make, how we can make it a little bit better the next time. Was there something that maybe we didn't see that we could have stepped in earlier? So that's quite important.

Occupational Therapy Lead CNTW:

So I'm an occupational therapist and my job is I am the clinical lead for the inpatient occupational therapy team. So that is the occupational therapists who work on the acute adult wards, the rehab adult wards, and the older people's wards. So I think kind of putting my occupational therapy hat on, I think how we approach things and what is important to us as occupational therapists is very similar to the ethos you guys have in whatever museum you work in. Our job is so much of our time with patients is dominated by symptom management, medication risk management, but as an occupational therapist, we are. So our focus is thinking about the person and thinking about what is meaningful to them, what they're interested in life beyond hospital. We've always got one eye on this isn't where they want to be in life. It's where our job is to support them away from hospital and to think about how they're going to be spending their time and how they're going to stay healthy away from hospital. And I think that's why I think our two organisations dovetail so nicely together because we're interested and we know the importance of people being engaged with things that they're interested in.

Angela Kennedy:

My name is Angela Kennedy and I work with organisations and leaders to create contexts where people can heal and flourish. So I think when arts and health come together, there needs to be some very transparent conversations about what both sides are wanting to get out of it and trying to find the win-win point of contact. There might well be different expectations, and if that's not clearly set up in advance, then both parties might be frustrated about what is happening. The only way of doing that through conversation, you have to have really upfront, courageous conversations about not just what you're able to do, but about what you can't do, what that isn't going to solve. It's also very difficult to have those conversations without people with lived experience in the room. And the more that you can offer them an equal place at the table, the more likely you are, you get something that meets their needs that they feel meets their needs, not what everyone else thinks might meet their needs.

Occupational Therapy Lead CNTW:

I think it needs a memorandum of understanding, some sort of document that pulls together our two service areas, an expectation of each other, whether you are the giver or the recipient, of why are we doing this and what are the aims behind this? How are we supporting each other to deliver this and where we're going with it as well. What are we doing with it? I think from ourselves as clinicians, and I have to say when the piece of workforce started and maybe it's kind of coming from that kind of leadership head that I have on risk is such a huge issue for us. It's something that is in our minds, patient risk, staff risk, visitors risk. And I guess for me as a manager and a clinician, it's I think a lot of thought needs to go into how are we making sure anybody who comes into our clinical space, because there can be such volatile, unpredictable environments, how do we make sure that people are safe and prepared for what they might encounter. We're trained staff, but there's still, there's incidents and there's words said and there's things done that can be really quite distressing to be around.

And we're trained with different ways to be able to manage that and deescalate that and then go away from work through the day and not think about that. But I'm very aware of how do we help other people develop, have an awareness of that, but also develop ways to process what they're around and to be prepared for the unpredictability of it. As an occupational therapist, and I've always worked in mental health, and one of the things that we always share with our students and newly qualified staff is whatever you plan to do, probably about 2% of the time you get to do what you've planned to do. Mental health is so, things change within a second. So you've got to, if you're coming into the ward environment with a plan to do something, it's almost like you need at least another 10 plans of what you're going to do when those things don't quite work out.

Angela Kennedy:

A true learning culture really sets up an openness of a mindset to look at the ripple effects that might be both positive and negative, and you don't always know what they are until you actually start doing it.

Occupational Therapy Lead CNTW:

So as a clinician, as a manager, I think it's very important before any of this work has started is to think about how do we keep people safe, physically, keep people safe, and help people emotionally be able to be around what can be varied to distressing environments.

David Luck:

So my name's David Luck. I'm the archivist at Bethlem Museum of the Mind. The Museum of the Mind is a museum onsite at Bethlem Royal Hospital, which is a working NHS psychiatric hospital. So we are embedded in the grounds.

Nuala Morse:

My name's Nuala Morse. I'm an associate professor in museum studies at the University of Leicester, and I'm really interested in a professional practice of museum workers who are doing work in this broad field of museums and health. So my research has taken different shapes over the years. I've done collaborative work with museums looking at how we measure the impact and the benefits of creative activities with museum objects in healthcare contexts. And I've also been looking at what are the different skills and competencies that museum professionals need to deliver this work. So thinking about the caring museum professional and what does it mean to do care work with museum collections.

David Luck:

I guess my role is in part to administer and give access to the history of Bethlem, which is the oldest psychiatric hospital probably in the world, certainly in Britain. And I also look after the records of the Maudsley Hospital and Warlingham Park Hospital as well, as well as doing many other things around the museum.

Nuala Morse:

Co-design is such an important aspect of this work, isn't it? But it can also be an area of real tension. So it's a really good place to start. I think thinking really carefully about what does it mean to co-design, what does it take to co-design these activities? So I guess co-design is about understanding that you're working across two sectors that haven't traditionally worked together, the health sector and the cultural sector. And so there is a bit of a gap there isn't there, in terms of practices, in terms of training and so on. And so that co-design approach is really important to bringing those two worlds together so that you're designing programmes which will have the best benefits and impacts for those patients or clients or community groups that you're looking to work with.

David Luck:

Yeah, I mean, so what I thought here instantly is it's that alignment of goals. It's making sure that you can demonstrate that what you are doing will have a real tangible benefit to the people that you are speaking to, and to be able to do that in a very sort of straightforward manner. So when the Change Minds Hub organisation came to us and said, this is what we've done in creating a programme that looks at heritage, that has benefits for mental health, that sort of thing, it literally ticked, I think we had something like five organisational goals and it ticked all of them. And so when something is that close, it becomes sort of question of why are you not doing it? Almost.

Nuala Morse:

I think co-design is imagined quite differently in the healthcare sector and in the museum sector. So I think at the outset of any programme, taking the time to understand where organisations are coming from, what their priorities are, where the areas of overlap are, and kind of focusing in on that to think about how you design programmes that can meet all the different aims of different partners.

David Luck:

The pressure on people means that the kind of goodwill that's really required in cross collaboration is being eroded really heavily. I think having a relationship with people is really important as well. An example of this, we've worked together with the anxieties unit on site here quite a few times, and it's taken this length of time for us to build somewhere where they're coming to us now and going, have we got a project we can work on together?

Nuala Morse:

I think at the heart of co-design, really the most important, the most important element is thinking about the end user, the patient experience. What are the clients or the communities or the individuals that you're designing your programmes for, what are they going to get out of it and also what do they want to get out of it? So co-design really, I suppose you might think about it as a three-way thing. You have healthcare professionals, you have your cultural workers, but you also have your patients and your clients and your lived experience groups. And so that co-design is around everyone's priorities, isn't it? And bringing it together to develop those experiences that can be really meaningful to the people who are taking part.

David Luck:

Yeah, it really does come down to building those sort of personal relationships. And again, that's where the museum is lucky to be on site because even a chance meeting can lead to the start of that. So to have that, having a presence on the hospital permanently is a really good thing for us.

Nuala Morse:

I think in some of the research that I've done, what we've looked to do is involve everyone in the research process. So that could be in the design of the research questions, but also in thinking about the types of research methodologies that we might use to capture and measure the impact that programmes are having on participants. And just taking the time to have those conversations can be really revealing of where people are, where we might think we're using the same language, but we mean completely different things. And taking the time to come together and unpack that and question it and work through where there might be some tensions.

Alisdair Cameron:

Alisdair Cameron, the day job is I'm co-director of ReCoCo. ReCoCo, stands for Recovery College Collective. We sit predominantly in mental health as an organisation. We are run by people with lived experience. That includes myself as co-director and other members of staff. There's lots of things are peer produced. We also interpret mental health broadly, so that covers people who've maybe never had a diagnosis to people who've been in services for umpteen years and acknowledges all of the crossovers. So there's a lot of people who have also got drug and alcohol issues. Also, a lot of people these days who are acquiring diagnoses around neurodiversity, lots of people with chronic pain and physical health problems as well. So yeah, it's being able to deal with people in the round.

Daniel Regan:

Hi, I'm Daniel Regan. I'm a visual artist and also the founder and director of an organisation called the Arts and Health Hub. And across my works, I am working in the creative health sector, either delivering projects or supporting artists that are working in the sector as well. I came into this kind of work through my own lived experience of mental health difficulties as a young person, and so I'm really interested in the ways that we can use arts and culture to support people to improve their health and wellbeing, particularly around mental health.

Alisdair Cameron:

It's particularly challenging at the minute because of the way that people are financially struggling. I mean organisations financially struggling, which means they tend to revert to doing core business only. But really for collaboration, you need to get people slightly out with their comfort zone and thinking in slightly different ways. So with heritage organisations, you might be thinking about outcomes which are not heritage or art related in a narrow sense with health organisations. It's not thinking necessarily about narrowly defined clinical outcomes. But again, thinking about other outcomes, some of the best ways of doing it really are try to make each partner feel equally uncomfortable so everybody shares a bit of discomfort. So it's doing something which if it's possible, takes everybody equally distant out of their comfort zone.

Daniel Regan:

So sometimes people enter into these kind of collaborative projects without being quite clear about either the data that they want or the resulting experiences. So being really clear about what it is that all the different stakeholders need. I was also thinking about the design aspect of a project. So when it's working with vulnerable people who has been consulted in the design, how has lived experience been involved in the design of the work so that it feels that it's a project for people by people that experience these difficulties. And then sort of very practically thinking about recognising some of the qualities and skills that organisations have, but also the limitations and thinking about auditing who is good at what and where are the gaps, and then plugging in those gaps.

Alisdair Cameron:

Central to that I think really is foregrounding people’s lived experience, but not going too far down a category route. By which I mean we're looking to forge collaborations between organisations and different sectors. So we need to try and make the boundaries between those sectors a bit more porous and acknowledge people can serve more than one purpose, and the same way that people have more than one identity. So someone could be someone who's got lived experiences using drug and alcohol services or mental health services, but it could also be an artist could also be working in heritage, so it could be a clinician. So it's acknowledging that things are multifaceted and trying to get away a little bit from that compartmentalisation and make everybody uncomfortable.

Zoe Brown:

We'd like to thank all the contributors to this episode of The Practising Mindful Practice Podcast series.