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 three, Understanding Clinical Environments. In episode three, we will discuss a range of practical matters, from parity of esteem and the hierarchy of value between clinical and psychosocial models. We'll look at addressing frictions that can occur between health and heritage professionals, security needs and different types of clinical settings, including perceived risk rules and regulations and risk assessments.

Can you tell me how you felt before you had ever gone into a locked forensic mental health ward? What perceived risk did you think there was going to be, what did you think the setting was like and how did you feel? But then actually, what was the reality like?

Clara Shield:

The first time I went onto a locked ward at St. Nicholas's Hospital site, I was semi-prepared in that I knew where to go, I knew who to ask for, and I was told that I'd need to press the buzzer and someone would come and let me in. So I knew all of that. I had with me a box of objects, which had been discussed loosely. However, I knew myself just to make sure that everything in that box was going to be appropriate for the group that I was working with. So I was carrying my box and I remember it suddenly starting to feel very real as I approached the door and pressed the buzzer and realised that I was going to be in this kind of vacuum where I would go in one door, that door needed to be then closed behind me before the next door would open.

And there was a big loud buzzer that indicated one door closing, another door opening as an alarm to let staff know when these doors were open. And then I started to feel quite nervous, I was really aware of what I was wearing. I was going onto a male adult ward, and I'd already maybe subconsciously thought about this when I was getting dressed that morning around making sure that I was wearing clothing, that I felt I was covered in a way that felt safe and I felt comfortable. So I'd obviously started to think about this without realising I was thinking about it. So I get into the ward and I meet the member of staff who immediately made me feel at ease and who just explained, oh yes, these doors, there's such a pain that you can't get through this door without the other one. And then that just sort of very casual conversation just helped reassure me.

And I just ask the questions, do I need to leave my coat and bag somewhere? What do I do with my mobile phone? And they said, you're fine, just as you are, just stay. Come as you are. Bring your box in here. Do you want us to help carry your box? Nope, that's fine. Just come in, right? We've got this room just set up here. And so I was really aware, well, I've got my rucksack, it's got my purse in, it's got my diary, it's got my phone and my car keys in. And they were like, yeah, just keep it on the floor next to you. That's fine. We're just going to be in here. And so that reassured me that they must only be saying this if the group and this environment is that safe. And then it became really clear that for the majority of patients on this particular ward, they all had a member of healthcare staff watching them.

They call it Eyes On. So I was never on my own. And the individual patients were never on their own. The minute they get up to walk out the room, a member of staff gets up and follows them, and that's their role to follow them. And that's when it started to kind of become, okay, this is how we keep everybody safe here. And I feel a lot safer. And the staff just was so, like I say, casual and calm, that it just helped create that sort of environment and culture for what that session was going to be like. So it was really, really nice. Some of the subject that I took was a bit too dry, so I realised that I needed to have more engaging, more visually stimulating activities for the participants. So I am very conscious of ensuring really that patients have an input into the session so that they are as engaging as they can be.

And then when I left the same process to leave the building was the same as on arrival. And then after that, I was far more confident. I knew exactly what to expect. It would've maybe been quite a useful experience to have visited the ward without having the pressure of facilitating a session. So thinking about improving practice and opportunities for the future of heritage workers going into these environments, having a visit, spending some time on the ward without having to think about what you're going to be doing and your session isn't going to work without having to have that worry, that would've been really great if there was one thing that I could have changed from that first visit and that first session on the ward. I think if you're working on a site with a variety of different wards where you might be experiencing different levels of security.

So for example, the wards that are forensic wards, you've got people who are serving a criminal sentence, but they're too poorly to be in another prison setting. So they are in a forensic mental health care setting. And so some of their crimes, some of their way of thinking could be unsafe dependent on, and that might be a feature in some of the sessions or who might come onto the ward. So there's a lot of additional risks and conversations that need to happen about what's going to be the best outcome for that session. For an acute mental health ward where someone is spending a short period of time, but they're very, very poorly, there is another set of what's appropriate. And then for the wards that are slightly more relaxed in that they're secure, but the patients all have leave and they can go offsite and as long as they're back on site by a certain time, that's absolutely fine.

So yes, it's varying degrees of what you need to know because of the patient's needs and the type of specific environment that is. And on one hospital site, you could get nine different versions of that. So just because you've been on one ward doesn't mean to say, oh, right, I've been asked to go into a different ward. It's going to be like that because the next ward I went onto, I was given a personal alarm that I had to wear at all times. So it just varies depending on the wards that you're on, but the key is to be prepared and to have that information. And that could be something that is clearly written up in the memorandum of understanding around the varying different wards. And that communication will be made between the heritage worker coming onto the ward and the staff that work on those wards to ensure the best possible outcome for a session.

Reece Watson:

My name's Reese Watson. I'm currently working as an occupational therapy assistant on the Fellside and Lowry Ward. However, my experience of working with the heritage boxes came when I was working as an activity facilitator, and that was on Bede Ward at St. Nicholas Hospital. Yeah, you've always got to be aware of obviously confidentiality with all patients, but if I feel the need to say like, oh, certain patients being unwell, they've been quite risky, that's totally fine to pass that on to Clara because at the end of the day, I want everyone to be safe. So yeah, just always, like I say, I'd call it a mini-handover, just if it's relevant for staff working on the ward who are employed by CNTW, then of course it's relevant for Clara who's going to be on the ward facilitating the sessions.

Clara Shield:

I have had lots of experiences throughout my work, working both in addiction recovery and in mental health, in my role as a museum heritage worker working inter-community settings and that way of managing those uncomfortable feelings or triggers or inappropriate conversations or direction of conversation, I've been able to manage that through my experience of working within community development. So I've drawn on all of the methodology around how to create your own boundaries, how to recognise, how to reinforce those boundaries, how to gently talk about boundaries and boundaries are there to keep us all safe and to introduce these at the start of sessions for patients and participants and letting them know they are equally valid for both participants in the session and also for the workers. They're there for all of us. So I've been able to use my own experience and I think that's what has helped me tremendously in a lot of my work where I can see that could have gone a very different way had I not had that experience and skills and training from my own professional background.

It is something that I do think heritage professionals working out into these community settings with, like you say, some very poorly people need to be prepared for, have the appropriate training and opportunities for additional training to help manage that. Because it is just sometimes luck that you are an individual who has done different jobs in different roles and developed that new and emerging professionals coming into the workforce may not have had that. So there's something around the heritage sector supporting that actually and ensuring that any new staff coming into work in these settings, which are some of the most fascinating environments to work in. And you can see some really wonderful moments where museums and heritage collections really do improve the outcomes, and even if the outcome is just in that day or the longer term outcome and recovery for individuals, there is such a space for that. However, it needs to be done in a way that's appropriate and safe for both the worker and for the participant. And you can't just count on experience if you're a new member of staff.

Zoe Brown:

And I was just thinking about things like knowing that people are on different types of medication and that medication, depending on what it is and when it's being taken and we don't need to know what, we wouldn't even know what the medication was that they were taking, but it's useful to know, look so-and-so might be a bit sleepy. Or if somebody is a bit sleepy, don't worry. It's just the medication. It's not because they're bored.

Clara Shield:

And the staff have, in my experience, been really good at that. So where we have had the odd occasion, the odd session where there's just been, sometimes the staff describes a different kind of vibe on the ward today, and that could be for a variety of whatever reasons, but it's had an impact on the patients. And so what the patients and how the patients behaved and presented last week might be very different this week.

And that's the kind of heads up, I guess, that the health professionals are trying to give me and they can't anticipate that. They can't say, oh, tomorrow it's going to be like this, or they can't say this afternoon it's going to be like this because things change so quickly. So it's literally when you get through the door, they'll then say, right, today looks like this right now this is how the group is. This is how many people are coming out of their rooms to participate. These are some of the things that have happened this morning just to give you the heads up. And they can't give you any more notice than that because it can literally be, and then things clearly happen in the moment in the sessions. So then there's the other element of how do you cope when the fire alarm goes off or another alarm goes off, or when the staff start running up and down the corridors because something else has happened. But you've always got that member staff there who just reassures you and explains this is what's happening. So again, it's all about communication and being flexible and being prepared for the unexpected.

So my experience of placements has been predominantly where students who are studying occupational therapy or similar have come on placement and they've come to shadow the work that I do. They've come onto the wards that I've worked on and obviously these are students who are in their very early stages of their career. So it's often quite eye-opening for them to be in those environments and very useful for them to see the value of where heritage fits within improving the outcomes for patients. Just something there that you're just talking about with to shadowing for myself, and I can really imagine where a heritage professional is given the opportunity to go into a mental healthcare setting or an addiction recovery setting and just observe, just shadow how the healthcare professionals do their day-to-day work and start to see where the heritage and creative part of what we do as a profession can complement that, but with no expectations that you're there to actually facilitate something.

You're there just to quietly observe and just learn and watch. I can really see that being something that could be really great if you are about to start a new programme of activity into a setting that part of maybe an induction before as a pre-programme set of sessions or days where there's this discussion around the memorandum of understanding, reading through it, ensuring everybody knows their roles and responsibilities and that it's there to support our practice. And then some practical experiences of being onsite where an activity worker may come and just observe what it's like working in the museums, collecting the objects ready to do sessions, thinking about planning a session, looking at our collections, looking at where the links are for particular groups, and then vice versa where the heritage professional goes and just observes a day on ward. I can see that being a really, really beneficial opportunity for both organisations, which may well then help adjust and change and inform the memorandum of understanding to be even more inclusive of some of the other responsibilities and guidance.

Alisdair Cameron:

Alisdair Cameron, the day job is 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 that 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.

Clara Shield:

When you are actually doing this work, particularly in that more clinical setting or within an agenda that is more about those clinical outcomes, what do you think would be the best advice and information you could share for heritage professionals who are at the beginning of a journey of developing this kind of practice?

Alisdair Cameron:

Well, a number of things. One is in terms of collaboration, don't do other people's work for them. Right, okay. I would say if you're working in the arts and heritage, don't take on stuff you don't feel necessarily comfortable with doing. So it's like you're not a clinician, so don't be suckered into taking on clinical roles and duties, but you can bring more of yourself into play in your interactions. And it's about forging those human connections really. You've got the person skills. Most people I've seen in arts and heritage are very accomplished with dealing with all kinds of audiences, all kinds of different categories of visitors. So you've got the set of skills. It's really about not being, you don't need permission really to speak to somebody who's in recovery from drugs and alcohol or mental health problems. Just another person. You are already equipped to do the work and don't let anybody tell you otherwise.

Clara Shield:

And with some of the, and especially in my experience of working on the wards in clinical settings, the actual environment particularly different in terms of delivering and facilitating creative workshops in a kind of arts or creative, just physical environment. It shifts and changes some of that approach and your self-awareness. Have you got anything to kind of share around experiences of that?

Alisdair Cameron:

Yeah, I mean, there is something that happens, and my views on this is slightly coloured by my own experiences when I was an inpatient. There is something profound about a sense of dislocation, relocation, I dunno what you want to call it. When you are taken from your normal place of residence and you are in a hospital environment and that then becomes your home environment, but it's not home. And I think there's a lot a of work yet to be done about it. I know there is work ongoing, but the actual physical environments of many wards isn't conducive to, they come across as impersonal, they come across as sterile. They come across as somewhat intimidating just in terms of the architecture and the way they're laid out, which are all impediments to some of that human interaction that you need. Thankfully, some environments, some ward environments are much better than that these days and ongoing work to be done about enhancing, creating more healing environments rather than medical environments. But it is a hurdle that needs to be overcome. It makes it much harder in a situation which is less homely or less artistic or less inviting to engage with people in a meaningful way. The milieu in which people find themselves, it's kind of de-personalising.

Zoe Brown:

You go into St. Nicholas's Hospital and you've got to go into, you've got to leave your bags, you've got to leave your phone. So that's part of people's identity. And then you've got to go into this area where you're going through a door and then it's locked behind you and you're going through another door and then that bit's locked behind you. Do you want to talk about any advice you give to heritage workers about that and perceived risk that they have got?

Alisdair Cameron:

Well, I was about to say something, but I dunno if this will be encouraging or not. To be honest. If you're going to visit a locked ward, it's probably a safer environment than some of the acute admissions wards at the minute, simply because people have been there and been receiving treatment and for longer, the level of acuity on the admissions award is really quite high. It's try not to forget. We're just talking about people and they've, they've got their weaknesses, they've got their faults, they've got their problems, but they've also got their strengths and they've got their interests.

There's nearly always going to be some point of contact you can make with somebody, something that they're interested in. It does help if you've got a very broad frame of references, really, so that you can talk about a suitable topic of, you can form a suitable topic of conversation. If your knowledge was really limited in terms of heritage to the Egyptian collection or whatever, it might be a bit tricky. And he didn't have other topics of conversation. But nearly all of the heritage and arts people I've encountered, they have a wider frame of reference than most. So that's an asset they're able to talk about, a phenomenal range of subjects, everything under the sun really.

Zoe Brown:

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