Report
May 2003

Kensington & Chelsea and Westminster
BME Health Forum

BME Health Forum

REPORT ON USER & PUBLIC INVOLVEMENT INITIATIVES

May—Dec 2002

PHOTO: A meeting held along the lines of a Cafe Process—organised by the BME Health Forum and Westminster PCT

IN THIS REPORT:

INTRODUCTION: New Approaches to User & Public Involvement and Engagement

As an independent multi-agency policy forum working on health issues related to BME communities in Kensington & Chelsea and Westminster, the BME Health Forum has co-ordinated a series of Task Groups focusing on particular health and health-related issues. This has included Substance Misuse, HIV and Sexual Health issues, involving BME communities in NHS Trusts' Race Equality Schemes, and Health Needs of Refugees and Asylum Seekers in KCW.

To compliment this work, the BME Health Forum organised a series of events and initiatives focusing on PROCESSES of partnership working, PROCESSES of user involvement, engagement and participation, and PROCESSES of consultation events. The aim of these initiatives was to introduce new methods and ways of working, ways that go beyond more traditional ways of involving stakeholders such as questionnaires, focus groups, and large consultation events.

These new approaches involved a policy workshop — **FROM 'USER INVOLVEMENT' TO 'USERS AS CENTRE STAGE'** - looking at new perspectives from whole systems approaches to engagement of communities in the change process. This included looking at: What is power and can we and do we want to share our power with users? Our local health and social care economy: how to create effective dialogue across and within different parts of the system? And an introduction to some of the techniques, information, and practice sessions.

This was followed by an OPEN SPACE EVENT looking at the issue of: '**How can we maximize BME community involvement in having a real say in developing health care in KCW?'**. The event was held in October 2002 and was attended by 74 people from community, voluntary and statutory sector agencies. It was facilitated by Roma Iskander and Kate French, both who have experience facilitating these initiatives. A follow-up meeting to the Open Space event was held 2 weeks later to look at finalising a list of principles that came out of the Open Space event, as well as looking at how we can feed the recommendations and ideas into on-going work and initiatives.

The December 2002 Quarterly Meeting of the BME Health Forum had the issue of Partnership Working as its main agenda item, and the meeting was run along the lines of a **CAFÉ CONVERSATION**. A seminar organised by Westminster PCT for their Board and PEC also used the Café Process in a workshop to inform the PCT's Involving People Strategy.

This report provides information on all these events, including some of the recommendations that came out of the events (for full details and recommendations, please see the BME Health Forum's website). In addition, this report includes various articles on whole systems events and partnership working, and an interview looking at how FORUM THEATRE, a participatory theatre form, has also been used in community-based health initiatives. Links and information on useful internet sites, publications and contacts are also provided.

AIMS OF THE BME HEALTH FORUM

The BME Health Forum is an independent multi-agency policy forum with over 260 members from local Black and Minority Ethnic groups in Kensington, Chelsea and Westminster, and representatives form local statutory agencies.

The BME Health Forum focuses on strategic policy issues and exchanges of information and ideas with the aim of engaging BME community groups in policy developments and initiatives related to health care in KCW. The work of the Forum focuses on the health needs of BME communities in the Royal Borough of Kensington & Chelsea and the City of Westminster, ensuring that their views are heard and acted on, and that communication, partnership and engagement between them and NHS Trusts, other statutory and voluntary groups is excellent.

The Forum aims to create an effective and sustainable mechanism for communication between Kensington & Chelsea and Westminster PCTs, other NHS and statutory bodies, and BME community groups and individuals, in order to empower communities to effectively engage in a debate between them and the local health services.

WHOLE SYSTEM EVENTS AND LARGE GROUP INTERVENTIONS

Excerpts from: **Working Whole Systems: Putting theory into practice in organisations** (*King's Fund*, 1999, J. Pratt, P. Gordan and D. Plamping) – reprinted with permission.

INTRODUCTION

Large Group Interventions is the name given to meetings designed specifically to allow large numbers of people to work together at the same time in the same room. They may last several hours or several days. They can be entirely successful one-off conferences. Participants may number hundreds or a few dozen and they are responsible for contributing what they know and for doing the work. There are usually no outside speakers.

Over the last 50 years a range of designs for large group interventions has emerged through the interplay of social psychology, psychoanalysis and systems theory. These designs enable all to have a voice; provide time to nurture relationships and establish genuine communication; and benefit from the potentially mood-enhancing capacity of working together with the same aims.

> 'One hundred and twenty local people working together over two days is about the equivalent of a whole year's work for one person'.

These designs are now sufficiently familiar that they are no longer 'special', and are being increasing taken into mainstream business meetings. If you are thinking of commissioning a large group intervention you will want to find a practitioner who will plan and design the intervention with you, and then facilitate it. Each large group has its own purpose and detailed design that tackles the issues of voice, dialogue, mood and energy. By far the best way to get a sense of what large group interventions feel like is to attend one either as a participant or as a steward. The next best is to watch a video.

Large group interventions have limitations. They involve large numbers of people for significant lengths of time. They require careful planning, attention to details of the logistics and experienced facilitators. They should not be used when you can achieve your purpose in easier or more familiar ways. They are not an effective way of, for example, consulting the public or implementing a planned reorganisation. When certain conditions are met, large group interventions can be Whole Systems Events and can later a system's behaviour. In our view a whole system event is part of the ongoing life of an adaptive human system. It is not a one-off event.

If your aim is to change the system's behaviour then the attraction of working simultaneously with large numbers of local people is that their time and attention are focused on a shared concern in a very public and energising way. Whole systems events may be designed especially to meet the needs of a particular situation. Or the design may start from one of the well-tried designs for a large group intervention that is then modified appropriately. One essential aspect of whole system events compared with large group interventions is that sufficient numbers of the people involved must recognise that their futures are linked, that they are part of an on-going interdependent system.

FIVE ESTABLISHED DESIGNS:

1. SYSTEM MAPPING

Systems mapping enables participants to recognise the complexity of a system of which they are a part, and understand better how it works. We begin with an 'archetype' – a description of a situation whose essentials repeat themselves again and again, though not identically, as in a stereotype. For example, a woman in her late 70s has a 'turn' at 10pm one evening when she falls over and seems a little confused. This is a situation that is recognised as immediately familiar to people with experience of older people. Participants describe how this situation might develop and this is mapped in public, on the wall. If participants have time and trust each other they will eventually begin to describe how things really happen rather than how they are supposed to happen.

Rationale: We initially developed systems mapping as a 'diagnostic' method that would allow us better to understand a local system. Participants immediately recognised it as an intervention in its own right. We believe its success lies in the way it emerges with people's own experience; enables conversation in the group; and leads most participants to a genuinely enhanced understanding of their experience by hearing other perspectives.

The method only works if the archetype is recognisable and if there is a good range of perspectives present. The map itself has meaning only for those who have taken part in the conversations that accompany its construction. Participants develop a much richer understanding of the system of which they are a part and a recognition of its complexity. Systems mapping is particularly useful early on for a group wanting to take the whole system approach.

2. OPEN SPACE TECHNOLOGY

'Open Space Technology' enables groups of 5-500 participants to manage the content of their meeting, which may last anything from three hours to three days. They have the opportunity to put on the agenda items they want to discuss, and then chose the discussions they want to take part in. Reports from each group are stuck to the wall for all to read, and may be copied and distributed later.

Rationale: 'Open space' trusts that people usually have the capacity to organise their own work if they are provided with a structure. 'Open space' is probably quite close to the minimum structure necessary for this self-management. Open space' can feel wonderfully liberating as a way of working, Once the 'Open space' begins, the organisers have no control about what discussions take place. If it is used as a whole-systems event, the planning takes much more time and effort to ensure that the issue is carefully refined and that a diverse mix of participants from all parts of the system that turns up on the day.

The emphasis on self-management ensures that most people get a lot out of meeting on this way, and that useful discussions take place. Whether anything happens afterwards depends on the issue and the participants.

3. 'FUTURE SEARCH' CONFERENCE

'Future search' is a tightly choreographed design that provides the opportunity for participants to spend two days creating their shared future together. They begin by building up a shared understanding of their past. They move on the honest conversations about how things are now, giving groups and organisations the opportunity to tell others what they are proud of and sorry about, and for the others to endorse those 'prouds' and 'sorries' they feel are important to bear in mind for the future. This brings participants to the point where they are ready to imagine a shared future that is grounded on the realities of the past and present which is aspirational. Groups present their imagined futures back to the whole conference in imaginative ways, and the shared themes from these futures are brought together in public to form the 'common ground'. In the final session participants select whichever 'common ground' theme they feel most passionately about and work together to plan what they might do after the conference to take it forward.

Walking into the room at the beginning of a 'future search' is quite a shock for most participants. The room is full of round tables, each with 8 seats. There is no platform, no expert speakers. Within 20 minutes everybody is on their feet, writing on large sheets of paper on the wall contributing their experience of the past.

4. 'REAL-TIME STRATEGIC CHANGE'

'Real-time strategic change' meetings allow a wide range of participants to spend 3 days contributing to the development of strategy. A typical meeting begins with a welcome from the 'top people' and an invitation to all those present to contribute to the organisation's strategy. Experts from outside and inside the organisation and including customers, give presentations that describe the environment of the organisation and some predictions about likely trends. Groups within the organisation have honest discussions about which of their contributions to the organisation they are

proud or sorry about, and share these with the conference as a whole. They identify what other groups in the organisation could do that would enable them to do their job better, and make requests directly to them.

Before the event, a strategy team have prepared a 'straw-man' strategy document; participants discuss the document in groups and share their comments and suggestions with the whole conference. The strategy team have the task of re-writing the strategy document overnight and circulating a new version for the final day. 'Real-time strategic change' is based on the premise that everybody in an organisation is capable of contributing to its strategy, and that people are more likely to implement something they have had a hand in creating.

5. APPRECIATIVE INQUIRY

'Appreciative inquiry' … can be used to engage large numbers of people. It is not a large group intervention but its originator … often uses it along with large group techniques. 'Appreciative inquiry' replaces the traditional problem-solving cycle with the possibility-finding cycle. In the discovery phase people share stories of exceptional accomplishments, discuss the core life-giving factors of their organisations, and deliberate upon the aspects of their organisation's history that they most value and want to bring to the future.

The dream phase challenges the status quo by envisioning a more positive and vial future—not out of thin air but grounded on examples from the positive past. It begins by valuing what has been found in the interviews by feeding them back in a report or meeting. The design phase involves creating the organisational forms that reflect and support the dream, and the final phase is an invitation to co-create the future—the opportunity to build the appreciative eye into the way the system works.

'What we ask determines what we find. What we find determines how we talk. How we talk determines how we imagine together. How we imagine together determines what we achieve' (David Cooperrider, originator of 'Appreciative Inquiry').

FURTHER READING, INTERNET RESOURCES AND CONTACTS

- **Six Major Models for large group interventions** - from *Using Large Group Interventions for Organisational Change*, Alban and Bunker, 1994
- **Working Whole Systems: Putting theory into practice in organisations** (*King's Fund*, 1999, J. Pratt, P. Gordan and D. Plamping) - contains comprehensive annotated bibliography and useful contacts
- **Participation Works. 21 Techniques of community participation for the 21st century** (New Economics Foundation, London, 1998)
- **Open Space Technology: a user's guide** (H. Owen, 1992/97, USA)
- Network of Open Space Practitioners in the UK and training events—contact Romy Shovelton—romys@compuserve.com
- For **information on Future Search Conferences**, see http://www.searchnet.org. UK contact is Perry Walker at the New Economics Foundation—visions@neweconomics.org.
- **The thin book of appreciative inquiry**, SA Hammond (1996)
- **UK network of practitioners of Appreciative Inquiry**—contact A. Radford—AnneLondon@aol.com
- **Info. on Café Conversations**, World Café, see http://theworldcafe.com
- **Hand-out on Café Process**—http://www.theworldcafe.com/cafetogo.pdf

PARTNERSHIP WORKING
By Kate French, Consultant in Organisational Development

MERGER…PARTNERSHIPS…COLLABORATION…NETWORKS

Our thinking about organisations – partnerships – how to change things – is being challenged via many disciplines

- How we think about partnerships depends partly on how we think about organisations: the 'machine' linear viewpoint or the 'complexity' non linear perspective – the difference between throwing a rock and throwing a bird [Richard Dawkins analogy]
- The linear, cause and effect type of thinking, 'one right way' approach is being questioned by economists, natural scientists, organisational theorists and others – complex adaptive systems thinking is challenging notions of control, change, progress, predictability and static order

Complex systems – some characteristics

- Thrive in tension and paradox – on the edge of chaos where innovation and creativity will occur
- Systems are embedded in other larger complex systems – leaders can't take up a position outside of the system and 'shout directions'
- Change is non linear – small changes can have big effects and big changes no effect at all
- Very complex outcomes can emerge from a few simple rules [principles for action] – lots of complex targets can stifle adaptive ability and creativity
- The elements of the system can change themselves – imposed change can lead to unhappy and unintended consequences – the lesson is not to make the bird become more rock like – bird behaviour, seemingly complex, revolves around a few simple rules – so change is successful where a natural pattern and advocated change are linked [the desire to be in a bird-bath]

Complex systems thinking does not address the notion of power and power differences between key players. In partnership development some agreement of what power is and how it is shared is necessary to achieve a more level playing field.

Generative relationships in partnerships

'When individuals with different experiences come together to act for some common purpose, they form a generative relationship that leads to creative ideas that leads to creative ideas that neither party could have dreamed up alone'. Brenda Zimmerman of McGill University presents 4 aspects of this relationship:

- **S**eparateness: differences in background, skills, diversity and active respect for difference – generating fuller picture, seeing things from various perspectives
- **T**alking and listening: real opportunities to talk and listen; permission to challenge the status quo; or implicit assumptions [see also Senge's notion of dialogue]
- **A**ction opportunities: acting together to co-create something new – this implies shared access to resources. It may involve lateral thinking, what other parts of the wider system can do to bring about change
- **R**easons to work together: there has to be some mutual benefit derived from the project

Rules, plans and structures to do things are necessary. It is suggested by those working with a complex adaptive systems framework that a few simple rules or minimum specifications are necessary. These specifications should:

- Point the direction of change [e.g. an action has to be taken/in place within certain time frame]
- Set absolute boundaries [e.g. can't go over budget limit]
- Provide resources for generative relationships
- Give permissions for trials or innovative approaches

INTER-ORGANISATIONAL NETWORKS

There has been considerable research in the development of inter-organisational networks across private and public sector organisations, and the findings of the research has relevance to more formal and informal types of partnership.

WHAT ASSISTS COLLABORATION?

- Valid rationale
- Choice based on likelihood of trustworthiness, shared strategy and understanding roles and cultures
- Flexible process that can take on changes in design
- Valid leadership and governance mechanisms – how to make decisions, lead organisation, information needs of all, rules of conduct and protocols

MOTIVES FOR COLLABORATION

- To increase resources, reputation, skills and enhance own organisation's legitimacy & validity
- Better output and outcomes
- Fast learning
- Reduce risk and improve stability where taking lead in innovation in uncertain climate
- To pursue common or mutually beneficial goals

TYPES OF CONNECTION REQUIRED IN COLLABORATIVE RELATIONSHIPS

- Flows of resources and activity links that lead to interdependence
- Flows of information to influence people's knowledge and perceptions and guide their decisions and actions
- Flows of mutual expectation that influence people's perception of risk and opportunity, fairness and trust

POTENTIAL BENEFITS

- Enhanced learning and innovation
- More rapid and effective decision making
- Improved responsiveness and flexibility

THE THREE PHASES OF PARTNERSHIP DEVELOPMENT

1. PRE NETWORKING

- Areas of interest of each agency
- Scrutinising joint interests and concerns
- Does each agency see the other as having status and legitimacy in the field?
- What are the perceptions of the relative power of each partner and how a partnership will affect the power base ofeach agency

2. DIRECTION SETTING

- What are the values of each partner and are there common values?
- What would be the common purpose of collaboration and what are our objectives?

3. STRUCTURING

- What structure do we want to take forward our work – types and frequency of meeting, membership, leadership
- What systems do we need to put in place to take decisions, share information, learn about each other's strengths, ideas and to agree areas of action

REFERENCES:

1. NHS Confederation leading edge briefing paper 'Why won't the NHS do as it is told – and what might we do about it?' Paul Plsek July 2001
2. Health Development Agency: Issues in Health Development Networked organisations – an overview Mike Pedler
3. The NHS Confederation Clinical Networks – a discussion paper 2001
4. South East Region NHS Managed Clinical Networks September 2000

Outcomes and Recommendations from OPEN SPACE EVENT and FOLLOW-UP MEETING

October and December 2002

In October 2002, the BME Health Forum organised an **OPEN SPACE EVENT** to look at the issue: '**How can we maximize BME community involvement in having a real say in developing health care in KCW?'**

The event was held in October 2002 and was attended by 74 people from community, voluntary and statutory sector agencies. It was facilitated by Roma Iskander and Kate French who both have experience running Open Space and similar initiatives.

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OPEN SPACE TECHNOLOGY

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Participants at the Open Space event suggested the following TOPICS FOR WORKSHOPS:

- Drug Services
- Is there such a thing as 'hard to reach groups' or do our procedures and processes exclude people?
- Depressing truth about childbirth: why isn't anyone interested in addressing this issue?
- Voluntary/Community Sector Involvement: 'Getting people when they are motivated to tell you something'
- Disabled People – Linking With Communities … Assessing Them … How?
- Service-Providers Need/Must Know and Understand Cultures
- What Do We Mean by 'A Real Say'?
- Community Participation in HIV/TB Control
- Adequate Funding – More Of It. But What Do We Do If We Don't Get More Funding?

RECOMMENDATIONS FROM WORKSHOPS:

Drug Services

1. Needs Assessment:
- Creative engagement of BME groups and individuals in needs assessment.
- Target groups through health info. Events, sports events, assertive outreach, schools events, all with drugs issues identified 'on back of event'
- Consult organized BME groups, faith groups, voluntary sector groups as to needs and unmet needs.
- Map existing BME service uptake against Borough stats on BME groups – where are the gaps – who are we not serving?

2. Integrate BME groups into all service planning bodies - drug service planning, DAT
Maintain BME involvement in service-planning as a core 'nuts and bolts' issue

Is there such a thing as 'hard to reach groups' or do our procedures and processes exclude people?

1. Ask people first to shape services around what they want – important ways to get engaged
2. Do people feel they have the chance to be listened to
3. Support communities to meet and identify needs and direct them about available services
4. Processes and procedures are defined by finite resources and processes are set because of that, plus structures and barriers which prevent implementation.
5. Hard to Reach – not only ethnic minorities, but people without organizations, e.g. homeless people
6. User involvement in general – are the demands of service-providers realistic? E.g. instant strategic thinking in a morning seminar
7. Are those who are 'hard to reach' the service-providers?
8. Meeting fatigue and repetition
9. Review and evaluate consultation and user involvement so far
10. Look at other formulas and processes, e.g. learning events
11. Transparency regarding roles of non-executive directors and how do they consult. Plus feedback to communities
12. Invest in relationships with individuals, using health professionals who work with individuals
13. How do the workers influence policy?
14. Changing the mindset of the professionals
15. Go where people are already going
16. Incremental approach - change little things
17. Address core funding for community groups
18. Power dynamics
19. Proliferation of groups – need for co-operative – to look for common concerns

Depressing truth about childbirth: why isn't anyone interested in addressing this issue?

1. Conduit of representation for women to be able to improve maternity services – especially at St. Mary's

Voluntary/Community Sector Involvement: 'Getting people when they are motivated to tell you something'

1. Value emotional responses
2. Reception areas and how these can lead to improvements
3. Posters showing how changes have resulted
4. Web of consultation, involvement and participation – valued and sought at all levels
5. Someone regularly phones round different parts of the organization to get service-users/ patients feedback
6. Voluntary and community sector involvement versus user involvement – what's the difference?

Disabled People – Linking With Communities … Assessing Them … How?

1. PD/LD issues are reported to be huge in BME groups, but we (WCC and WPCT) aren't getting to hear about what they are in Westminster
2. Do we need to break down our organizational barriers and undertake a joint consultation event – PD/LD, older people (what about 'consultation fatigue')?
3. Do groups trust us (WCC/WPCT)? If not, why not. We need to be honest with ourselves
4. How much difference/influence can groups have: so much of our work is driven/dictated from the center
5. LD/PD Services undertake joint events (consultation, information, celebration) for groups on relevant topics (our barriers aren't their barriers).

Service-Providers Need/Must Know and Understand Cultures

1. Importance of making time to make the right approach
2. Difficulty in covering all BME groups. This can be handled by making the right approach to the right people in the right way
3. Don't just send out invites—Identify the right person to speak to
4. Let's try to be inclusive, and mean it in practice
5. Raise awareness of issues affecting BME groups. Importance of maintaining up to date social mapping/surveying of BME groups/communities
6. Approach individual sections of community groups when dealing with specific/focused issues. More general health topics can be dealt with in more general ways: open days, etc.
7. If planning to do something and unsure of how to do it, check it out with people who know – the importance of networking individuals who to speak to for advice

What Do We Mean by 'A Real Say'?

1. Balancing the need for user views on a specified issue, while also allowing/enabling the issues users want to talk about to be discussed and listened to
2. Address 'consultation fatigue' and co-ordinate
3. Allow the consultation agenda to be set more by users
4. Identify consultation needs in advance by asking communities
5. Acknowledge that consultation programmes need to be evaluated and changed if necessary
6. How much power are providers prepared to give up?
7. Involvement as opposed to consultation – on an ongoing basis
8. If meetings can go ahead without users present, then how valid is the involvement process?
9. Concerns about 'Professional' or 'Super' users—feeling that 'super' users disenfranchise other users
10. Need to ensure that participation is only part of a broader user involvement system
11. Get away from inter-agency conflict/politics to ensure more targeted consultation
12. Providers need to plan better and work together better
13. The community actually setting up/running consultation agenda and inviting providers
14. Informing users/community about their rights and how they can participate
15. More money to support the development of user involvement self-help groups
16. Developing users as providers
17. Much better understanding of the limitations both 'sides' work under
18. Don't impose statutory processes onto community/voluntary sector/small groups – it can stifle them
19. The voluntary/community sector using its strength in this area to reach satisfactory agreements on working together
20. Learning from each other about user involvement
21. Building informal feedback systems into formal structures
22. Much slower, pre-planning systems for user-involvement
23. Value the 'same faces' who are committed over a long period
24. Time limited and topic-specific, focused ways to get users involved.

Community Participation in HIV/TB Control

1. Communities not involved because some are in denial of HIV and TB in their community.
2. Denial due to stigma. Nobody talks about sex – neither parents and children or husbands and wives.
3. Dispersal: e.g. the Liverpool Eritrean community group is HERE, not in Liverpool
4. Problematic for mothers re: new baby; new to London; new HIV diagnosis; doesn't speak English
5. Is it better to get community involvement, or someone from outside? Problems with both: Community involvement = disclosure. Someone from outside = community group do not want someone from outside telling them what to do
6. Get an 'insider' who knows the culture and issues. Insider involvement needs funding
7. Need good relationships and common organizers to allow you access to the group
8. Do not advertise as a 'health' event – no one will turn up! Advertise a cultural event and slip in the message. Poetry and art are very important.
9. South Africa/Zambia: strategies to challenge stigma of TB, give it back to the community, e.g. community supervised treatment
10. Providers' organizations need to address community participation Long-term, not for 6 or 12 months and then pull out
11. Look at structures that work in countries where BME communities come from, that address HIV/TB, and adapt here. Do not reinvent the wheel
12. Involve religious leaders conference; reps from Muslim gay and Lesbian groups
13. HIV awareness/education – be aware that mode of transmission in BME countries may be predominantly blood transfusion; therefore be sensitive to how awareness/education is delivered
14. People are depressed, therefore don't care about safer sex. They may be able to address HIV by using Mental health as a vehicle
15. Community to be involved in training professionals
16. Communities need support to negotiate funding through the frameworks that commissioners use
17. Evaluate the approach.

Adequate Funding – More Of It. But What Do We Do If We Don't Get More Funding?

1. The need for more transparency
2. Groups so diverse chasing the same pot of money
3. Community groups wasting most of the time filling applications, looking for funding
4. Uncertainties when funding runs out or is about to run out, it affects staff morale
5. Potential for more co-ordination with respect to user involvement, e.g. Patients' Forums
6. Drive to divide and rule and to institutionalize
7. User involvement is not only about money, but about power/decision-making
8. Community groups to be compensated for carrying out consultations on behalf of statutory organizations
9. Commissioners to come out to communities
10. At the time when NHS have all these plans for user involvement, community groups have no funding
11. Small community groups closing down due to lack/no resources, therefore statutory services such as social workers left with no backbone, i.e. the support of community groups
12. Community groups to be realistic about their limitations
13. Statutory services to be honest and open with BME groups re. Their applications for funding
14. Groups to get feedback on their funding applications
15. Raising awareness with community groups about the realities of funding.

FORUM THEATRE:

An interview with Frances Rifkin, Theatre Director and Director of UTOPIA

WHAT IS FORUM THEATRE?

Forum Theatre is a participatory theatre form. It was developed in Latin America by Augusto Boal as a way of working to tackle the over-riding problems experienced by ordinary people. It has been seized on, developed and adapted all over the world. Currently practitioners are applying it internationally and in the UK in Health Education, Community action and development, work in prisons, theatre-in-education and schools work, drugs and HIV awareness, in consultative projects and in many other areas.

Forum Theatre relies upon presentation of short scenes that represent problems of a given community such as gender for a conference on women or racial stereotyping for a class on racism. Audience members interact by replacing the protagonist in the scene and by improvising new solutions to the problems being presented. Forum Theatre is one of a number of participatory processes in *Theatre of the Oppressed*, pioneered by Augusto Boal.

A typical session begins with exercises and games aimed at initiating a playful, creative approach to what may be serious issues. A scenario or a set of images or tableaux is prepared by the group around what is of interest and importance to them. When the work is shown to an audience or worked within the group, everyone is encouraged to intervene to change the situation or resolve the problems. It is a theatre form that is entirely determined and developed through participation.

The aim of *Forum Theatre* is to enable participants to become not spectators but "spectactors" - rehearsing change by exploring the alternative courses of action open to the protagonist of the piece and carrying the experience through into everyday life. Through the "spectactors" interventions, the theatre piece becomes a kind of 'theatrical debate' where ideas, experiences and new courses of action and solutions are shared, leading to a sense of empowerment, solidarity and learning.

BME Health Forum: Can you tell us about previous projects you have been involved with that used Forum Theatre in a community or community health setting?

Frances Rifkin: We were asked by the London borough of Hounslow's *Community Initiative Partnership (CIP)* to create a piece of advocacy theatre for older people living in Hounslow, to be performed at the Older people's festival. We sought and received funding from the National Lottery, the London Borough of Hounslow, Unity Theatre and Age concern England. We ran a series of eight workshops in a range of venues from day centres to the Hounslow Pensioners' Forum.

We started by challenging the existing power base and power structure by using the games and exercises of Forum Theatre. We asked people 'what makes you angry?' and what came out was tons of material about their concerns and priorities. We used instant forum theatre – if someone said they wanted to have a go at Tony Blair, we produced him for them or if they wanted to take their GP to task, we put a scene together. Hilarious and moving stories came out as well, for example, of people's memories of the army during WW2 and of their childhood in west London. There were lots of alarming stories about their interactions with health and social services - waiting for hours to be taken to a hospital appointment, calling the doctor as a very elderly and infirm patient and being told rudely to get into a taxi and go to the surgery, being unable to access services and equipment they needed, feeling socially invisible, being excluded from every day life, feeling unsafe and insecure, not being heard. We reported regularly to the Older People's Festival Committee.

The performance, "Speak Up!" was by two professional performers. It used the words, stories and views of the older people and included actuality video footage from the workshops - interviews we had done with people in their homes, in residential homes - about what they thought of their lives, their youth, how they felt about being old, etc. It was funny, serious and stimulating and included forum theatre scenes in which the audience could participate.

Frances Rifkin: I also worked for 2 years with a theatre group of mental health service users in Newham, Mind citizens. The idea was to run a series of workshops with a small group, and create a performance. The group was composed of, and controlled by, users of services only, and all the users were also artists-singers, cartoonists, etc. We worked with 2 groups over the 2 years, and in the second, we brought in a professional writer, Brian Oliver, who worked with us. In these workshops, as well as Forum, we used a process known as *Playback Theatre,* a therapeutic form which plays participants stories back to them using richly coloured cloths in complex images. We got extraordinary stories from the group's experiences.

Interspersed with these life stories, we included reports from their experiences of using mental health services. We held about 8 workshops to rehearse the play, "Breaking Through", and 3 days technical rehearsals in Stratford Circus. We employed a professional team of designer and technicians to support the non-professional cast and the final performance became a wonderful celebration of mental health in front of a delighted audience of local users and their friends.
I have also worked with the Public Policy Research Unit (PPRU) at Queen Mary University in East London using *Forum Theatre* with many groups including, for example, a day with a group of NHS staff - doctors, nurses, GP practice receptionists and Midwives. The aim was to enable the group to look at their own issues and concerns. One forum piece they developed was set in a doctor's waiting room. A woman suddenly started to give birth in the waiting room and everyone went into emergency mode. What came out during the performance was that the staff tended to ignore all suggestions from the other patients in the waiting room, even shouting at any who tried to help! Doctors tried not to be involved and the midwives were very bossy! The group were profoundly shocked by the piece they had developed and it really did help change their behaviour – they re-ran the scene exploring ways to draw on the initiative and experience of everyone.

I have also been involved in projects that use *Forum Theatre* in consultative processes. For example, in a PPRU-run Crime and disorder survey for the Community Safety Committee in Tower Hamlets, I worked with a group of boys in danger of offending. They did a great piece about street fighting. We also worked on a piece with Bangladeshi women where we developed a monologue based on their stories and life experiences. These were performed for the committee as part of the report-back on the survey.

BME Health Forum: **If groups are interested in using *Forum Theatre* in their work, can you tell us about the logistics in terms of planning - for example, the number of workshops required to produce a performance, etc.?**

Frances Rifkin: The minimum session I would suggest is 2-5 hours, although this might not be enough to produce a final piece for performance; rather this would be an introductory session. Ideally, if a group wants to develop a piece for performance, they would need about 6-8 half-day workshops and some preparation time for the performance. It depends on how elaborate they want to be and what and who the performance is for. Forum workshops are an excellent way of developing debate and decision-making in action for a group – a day's work can cover this but really, it's important to assess what a group wants and develop the timescale to suit them – a half-day at the right moment might be very valuable. Forum workshops have lots of applications – helping to improve exploration and thinking around chosen themes and issues at conferences and meetings or in work or play situations. Above all, they are fun and help people to playfully and powerfully challenge worn-out ideas and discover new ways of doing things, to rehearse change in a safe theatre space as a practice for action in the outside world.

CONTACT DETAILS FOR FRANCES RIFKIN: Utopia, frifkin@aol.com, Tel: 020 7485 4981

WEBSITES AND FURTHER INFORMATION ON FORUM THEATRE AND THEATRE OF THE OPPRESSED:

- SOCIAL ACTION FOR HEALTH—http://www.safh.org.uk/ - SAfH have worked with Frances Rifkin and UTOPIA on a series of workshops training community workers in Forum Theatre techniques. Contact Ferhat Cinar at SAfH: 020 7247 1414
- Background Information on THEATRE OF THE OPPRESSED and AUGOSTO BOAL—http://www.unomaha.edu/~pto/
- CARDBOARD CITIZENS—http://www.cardboardcitizens.org.uk/main/about.php

USER INVOLVEMENT:
From 'User Involvement' to 'Users at Centre Stage'

OPEN SPACE EVENT

'How can we maximize Black & Minority Ethnic community involvement in having a real say in developing health care in KCW?'

Organised by the BME Health Forum

1 October 2002, 9.30am – 3pm

To be held at the Muslim Cultural Heritage Centre
244 Acklam Road, London W10

The BME Health Forum organised a strategic policy workshop in May 2002 to look at some of the newer and more critical perspectives on strategy and organisational / community change, and how consultation at the community level needs to be informed by such perspectives.

Following the workshop, we have now organised an Open Space event to look at the issue of BME community involvement in developing health care in KCW. This event will be held on 1 October 2002. The event will be facilitated by Roma Iskander. Roma has undergone training in the field of large group interventions including with Harrison Owen (the creator of Open Space Technology meetings) and Birgitt Williams who has developed OST as a process for organisational and community development.

This event is free and open to all in KCW —from community, voluntary & statutory sector organisations. See over for further details, or contact the BME Health Forum 020 7725 3252.

Kensington and Chelsea NHS
Primary Care Trust

in co-operation with the BME Health Forum

Seminars on Public & User Involvement in K&C PCT

This series of 3 seminars will look at processes of public & user involvement and partnership work in K&C PCT, particularly issues of partnership work and how best to involve services users and local residents in these initiatives.

The seminars will look at how change happens and how we develop strategies that enable change; user & public involvement in a context of complex adaptive systems; dynamics of partnerships; how to use different methodologies to better enable involvement and engagement; and what structures and systems do we want to take this work forward.

The seminars are free and open to all staff in the PCT, as well as representatives from local voluntary & community groups and local residents in Kensington & Chelsea. The seminars will be facilitated by Martin Fischer, Fellow in Organisational Development at the *King's Fund*. Where possible, people are encouraged to come to all three seminars.

1. HOW CHANGE HAPPENS AND HOW DO WE DEVELOP STRATEGIES THAT ENABLE CHANGE

Wednesday 6 November – 2.00-3.30pm
Venue: K&C PCT, 125 Old Brompton Road. Nearest tube: South Kensington

2. INTRODUCTION TO DIFFERENT METHODOLOGIES

Wednesday 20 November – 10am – 11.30am
Venue: The Chapel Meeting Room, St Charles Hospital, Exmoor Street, W10

3. TAKING THE WORK FORWARD IN K&C

Tuesday 3 December – 12.00 – 1.30pm
Venue: The Chapel Meeting Room, St Charles Hospital, Exmoor Street, W10

TO RESERVE A PLACE FOR THE WORKSHOPS, PLEASE RETURN SLIP TO:

Aisling Byrne, BME Health Forum, 50 Eastbourne Terrace, London W2 6LX
Fax 020 7725 3340; E-mail: aisling.byrne@westminster-pct.nhs.uk

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SEMINARS ON PUBLIC & USER INVOLVEMENT
Organised by the BME Health Forum and K&C PCT

I would like to book a place for the following Seminars: 1 _____ 2 _____ 3 _____

Name: _____

Department / Organisation: _____

Tel: _____ E-mail: _____

OUTLINE OF WORKSHOP:
From 'User Involvement' to 'Users as Centre Stage'

To be held on Wednesday 15 May 2002, 9.30 am – 4.30 pm in Room 305, 50 Eastbourne Terrace, London W2

Organised by the BME Health Forum, KCW

TRAINER: Kate French, Trainer & Consultant in Organisational Development

OBJECTIVES

- To explore diverse approaches to user involvement and to consider new perspectives that challenge traditional practice
- To analyse the deployment of power and influence and how this can be exercised to enable the least visible and audible in our communities to be present
- To consider practical techniques and approaches to enabling the expertise of users to influence policy
- To review how robustness can be built into professional/user partnership work

PROGRAMME

Session 1: **Stakeholder perspectives review (Small group activity)**
Exploring the perspectives of diverse users: what is their likely assessment of how our organisations work in partnership with them? What are our problems in working with service users?
Discussion: to pull out useful pointers for building effective dialogue with users

Session 2: **Some new perspectives from whole systems approaches to engagement of communities in the change process**

- The modernism top down approach to the post modern diversity perspective to working with users
- The contribution of whole systems thinking in relation to influence and change
- The notion of 'dialogue' and the thinking behind this concept [Senge]

Session 3: **What is power and can we and do we want to share our power with users?**

- Types of power
- Letting go of power
- Enabling and equipping others to be powerful who have had little access to power

Session 4: **Our local health and social care economy: how to create effective dialogue across and within different parts of the system**

- Mapping key inter – connections across the system[s]
- What small wins can we achieve?
- What longer term changes do we want to see?
- First steps of any change process identified as needed

Session 5: **What else do we want to know about techniques, information, practice sessions?**

- Plan of follow up sessions/workshops
- Review of content and process of the day

This report was produced by the BME Health Forum (March/April 2003)
Kensington & Chelsea and Westminster
Edited by Aisling Byrne

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