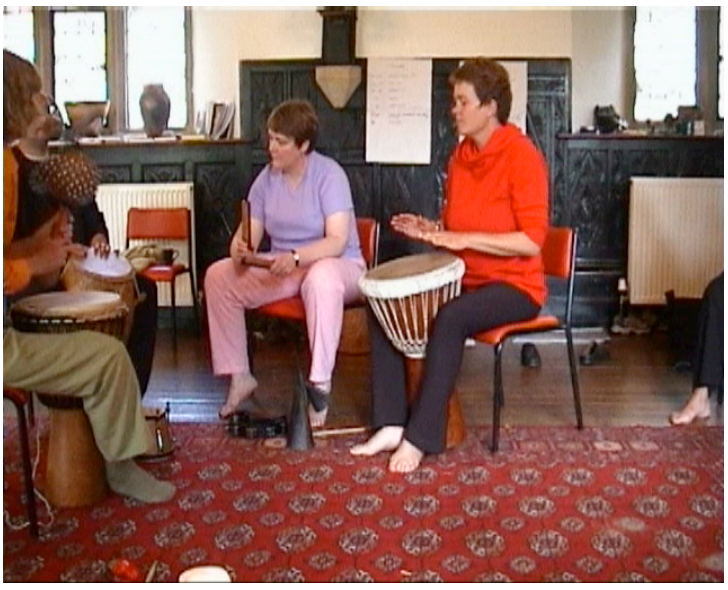
Chapter Seven

Being Creative in Practice

In this chapter I tell the story of how I first began to introduce a creative approach to my work as a facilitator of healthcare improvement. I reflect on how this happened in synthesis with my exploration of how I could apply my growing understanding of complexity theory to organisational development. My main focus here is on the connections I have made between my learning as a creative practitioner, what has influenced my thinking in this respect, and my growing understanding of how I might apply this learning within a complex organisation in order to work with others who are engaged in a process of improving services. I do this by exploring the process by which my knowledge and experience of the creative process has enabled me to create a way of synthesising what for me were becoming crucial parts of my practice. I also consider in what way my practice was changing and developing as a consequence and what impact this has had on the people I have been working with.

In the first section I reflect on the reasons I believe that we as adults can often develop a reluctance to be more creative, especially in the workplace and what I believe can be lost as a consequence.

The importance of play



Actors use a variety of exercises and games throughout their education and development and also when working professionally, particularly within an ensemble setting. The purpose of this creative play is manifold but is primarily involved with the development of creativity and spontaneity. Human beings are naturally playful, as children we respond to and learn behaviours and make sense of the world we live in through our play. At some point this process seems to stop and we begin to develop the social masks we wear in order to portray to the world the image of ourselves we wish others to see. Children also use play to explore and develop their physical selves in relation to others. Children seem to be much happier than adults to physicalise their play; they do not rely solely on words when they are creating imaginary scenarios. For many of us this playful side has almost disappeared by the time we enter secondary education. At this point we have already begun to display the social masks we have begun to form. We very soon forget how to play and even worse find the suggestion of play terrifying, play becomes a silly activity for many and reserved for small children. I also believe that our system of education contributes significantly to our diminishing ability to play and to be creative as we are prepared for the world outside of our schools, colleges and universities.

As we enter the world of adulthood and join the workforce our physicality can also begin to change and becomes shaped by the kind of work we are engaged in on a day-to-day basis. This is particularly apparent if we are engaged in an activity that is repetitious. For example, if we are sitting at a desk all day we are only really using the top halves of our bodies leaving the rest of our body inactive. Augusto Boal has explored this in great detail and makes the claim that the roles that we undertake on a day to day basis impose on us a mask of behaviour that can result in those of us who undertake similar roles even beginning to resemble each other.

"Compare the angelical placidity of a cardinal walking in heavenly bliss through the Vatican gardens with, on the other hand, an aggressive general giving orders to his inferiors. The former walks softly, listening to celestial music, sensitive to colors of the purest impressionistic delicacy: if by chance a small bird crosses the cardinal's path, one easily imagines him talking to the bird and addressing it with the amiable word of Christian inspiration. By contrast, it does not befit the general to talk with little birds, whether he cares to or not. No soldier would respect a general who talks to birds. A general must talk as someone who gives orders, even if it is to tell his wife that he loves her. Likewise, a military man is expected to use spurs, whether he be a brigadier or an admiral. Thus all military officers resemble each other, just as do all cardinals; but vast differences separate generals from cardinals" (Boal, 1979. p. 127).

Do we need to be creative?

In my role as clinical development facilitator and educator I wanted to explore the possibility that clinical practitioners, service users and carers could use the same creative skills and processes that actors use to develop a practical understanding of communication, leadership, problem solving, group interaction, relationship, team work, trust and the coping strategies for working within a complex system. An important part of this inquiry has been to test the validity of my belief that the creative arts can play a major part in making us become more effective by helping us to focus on the way in which we as individuals interact both as people and as professionals. I am doing this by showing how I have been developing what I believe are transferable skills that can be utilised in the workplace and have enabled me to use a range of techniques. This process has meant that I have had to refocus my perceptions of (my)self, others and the

context within which we interact as well as the process of interaction itself.

I feel very strongly that this development of our creative selves is essential when we are looking to improve services, albeit in a scientific way. In many ways I believe that the current emphasis on measurement and outcomes within the health service has led to an imbalance between the Arts and Sciences. The late physicist David Bohm spent much of his life exploring the relation between creativity in art and science. When he was asked if he saw creativity as a cornerstone of science he replied in the following way.

"….. many people have realized that creativity is an essential part of science. Creative insight is required for new steps. I feel that creativity is essential not only for science, but for the whole of life.

If you get stuck in a mechanical repetitious order, then you will degenerate. That is one of the problems that has grounded every civilization: a certain repetition. Then the creative energy gradually fades away, and that is why the civilization dies."(Bohm, 1998. p. 60).

I was beginning to explore the possibility that if I was able to engage clinical teams in creative activities it may be possible to see an improvement not only in the way that they work together as a team but also in the way that they focus on the transformation of their practice and a as a consequence see an improvement in services. This would require a different kind of engagement, a different kind of participation and I believed that a focus on creativity could contribute to this. I was beginning to develop an understanding of how a complex system such as a healthcare organisation might benefit from my creative skills. Margaret Wheatley (1999) refers to "the new science" and how it can be applied to

organisational life. She describes how living in a quantum world requires a move from tasks to a focus on relationship.

"To live in a quantum world, to weave here and there with ease and grace, we need to change what we do. We need fewer descriptions of tasks and instead learn how to facilitate process. We need to become savvy about how to foster relationships, how to nurture growth and development. All of us need to become better at listening, conversing, respecting each other's uniqueness, because these are essential for strong relationships. The era of the rugged individual has been replaced by the era of the team player. But this is only the beginning. The quantum world has demolished the concept that we are unconnected individuals. More and more relationships are in store for us, out there in the vast web of life."(Wheatley, 1999. p. 39).

As I engaged with writers of complexity theory, so much of what they were writing about was ringing very loud bells in my ears. The issues they were beginning to focus on such as relationship, listening, conversing were very similar to the issues we had addressed in theatre in education and theatre for development. They were not as yet able to demonstrate in what way this was changing their own practice, nor were there any practical examples of the use of creativity to develop this theory. By engaging with this literature I have been able to develop more confidence in my practice and this confidence in my creative experience encouraged me to begin to explore the use of creative approaches to my healthcare facilitation. Undertaking an inquiry of my practice throughout this process has also enabled me to understand and then to demonstrate how I have clarified the meaning of my ontological commitment to a passion for compassion in my practice into a living, inclusional and responsive epistemological standard by which my practice may be judged.

In the spring of 2001 I was invited to a conference in Bologna in Italy to present, in poster format, some of the work that I had been undertaking with the Dementia team in Swindon. (See chapter 6, Breaking Down the Walls of Silence.) The conference was aimed at those individuals and teams, both clinical and non-clinical, who had been involved in quality improvement. Although many of the sessions reflected work that had led to improvement these sessions were mostly concerned with the development of models for improvement. The last session I attended was slightly different, it was being run by the project lead for the Royal College of Nursing leadership programme and it was a very interactive and creative session. I stayed behind to talk to her about the work that she was doing and discovered that we had several mutual contacts. One of these contacts was at that time the Royal College of Nursing lead for Research and Audit. I had first come across her about a year earlier when I was clinical development coordinator; this is an extract from her email that I received from her completely out of the blue.

Marian,

I have just been informed that deep in the heart of Swindon there is a clinical audit facilitator who is not only a qualified nurse by background but is also a trained actress. I cannot believe that this can possibly be true but if it is can you contact me because I think you can help with a piece of work I am struggling with.

She had been asked to present something about clinical audit at the first National Institute for Clinical Excellence conference. She was keen to take the opportunity to present something that would attract and captivate the audience but would also communicate a few lessons about the process of clinical audit. She already had a keen interest in theatre and particularly its use in education and she wanted to use theatre in her session but was

having difficulty trying to devise something as she had never attempted this before. This was a moment when I had to make a decision, a very important decision. I knew of course that I could help her to create a session that would have the potential to do all the things she wanted to. I also knew that I would be taking a risk, a personal risk in a very public way. The time had come for me to begin to introduce theatre-in – education / development and theatre methodology into the clinical quality improvement arena. I had of course been using techniques drawn from the theatre when I had been working with teams but to date this had been very much a cloak and dagger exercise and I had never been explicit about the methodology of my practice. Here was an opportunity for me to come out of the closet in order to develop that work further, but I also knew that once out, I wouldn't be able to run back in again. For me this would involve me taking a risk but despite this risk there really was only one answer I could give her, of course I would be delighted to help.

The session was held at the conference in Harrogate and was fairly straightforward and involved mainly improvisation. I played the role of facilitator so I could stop and start the proceedings at any time and she played the role of Joker (Boal, 1979) inputting ideas from the audience as they attempted to improve the situation from the position of observers of the action. Involving the audience as participants in the action is what Boal refers to as 'spect-actors' in 'Forum Theatre'. In Forum Theatre a problem is shown in an unsolved form, to which the audience is invited to suggest solutions. Forum theatre was developed by Boal and described in detail in 'Theatre of the oppressed.' Boal founded theatre of the oppressed on his conviction that theatre is the most effective language, he describes forum theatre in the following way.

"The theatre, which is, in its most archaic sense, our capacity to observe ourselves in action. We are able to see ourselves seeing! This possibility

of our being simultaneously Protagonist and principal spectator of our actions affords us the further possibility of thinking virtualities, of imagining possibilities, of combining memory and imagination – two in dissociable psychic processes – to reinvent the past and to invent the future. Therein resides the immense power with which theatre is endowed. This is the theatre which fascinates me, and the method which I have developed and elaborated over the past 25 years, the Theatre of the Oppressed, tries to systematise these potentialities and render them accessible to and useable by anyone and everyone."(Boal,1998, p. 7).

These comments and observations from Boal also, for me, made very strong links with action research and in particular that of "Living Theory", (Whitehead, 1989). In particular the process of observing ourselves in practice and imagining other possibilities or solutions to issues is a very similar process and both have the potential for transforming practice.

Following the session we asked the participants for feedback and they commented that they had felt included in the action and that this had enabled them to contribute to the action in the scene and more importantly to change the action in the scene when they saw it was appropriate to do so. The changes that they suggested were based on their experiences in their 'real' world. They were able to play out possible solutions in this safe environment that perhaps they would be more anxious to try out in a real situation. They had engaged in a conversation about how to move the action forward and share their extensive knowledge with each other. They were also able to share the concerns and problems they were facing on a daily basis because they had been stimulated by their recognition of what was being played out in the improvisation. This event had a very powerful effect on me. I was both ecstatic and disturbed, I knew how theatre could be used as an educational and developmental tool, as a vehicle for creating positive group dynamic and also I would go as far as to say making a contribution to social transformation. At the time I was working in a role

where I was expected to engage clinical teams in an improvement process; I had had a superb grounding in theatre, why wasn't I using it more? On reflection up until this moment it would have been very difficult to do any more than I had done no matter how frustrating this was. I was working in an environment that valued measurement and outcome within a drive for evidence based practice, where the gold standard for research was double blind randomised controlled trials. I was unable to provide an evidence base for this approach to organisation development but I was also convinced that by engaging clinical teams in creative activities there was the possibility that they could not only improve the way that they work together as a team but that this may also contribute to the transformation of their services.

Even as recently as 3 or 4 years ago the culture within the NHS would not have embraced this kind of working. In my experience all the improvement processes had been concerned with outcome. The NHS has invested a great deal of money into the creation of models for improvement. What all these models appear to have in common is that they try to deal with all situations in exactly the same way. They work on the principle that if you reduce everything down to its smallest component parts you will be able to understand, and as a consequence, be able to control the system. How you actually got to the point were you could make improvements wasn't a priority so long as you came up with the goods and measured in a "Scientific" way any changes. It wasn't really surprising that most improvement projects were seen to be failing and despite the huge amounts of financial support there was concern that nothing very much had actually improved. Not long after my return to the health service and in particular the second half of the 1990's there was much questioning of the value and cost-effectiveness of quality improvement activity and in particular clinical audit. An extract from an article published in the Health Service Journal highlights this debate.

Following a critical report from the UK National Audit Office in December 1995 it was reported that, 'the Department of Health is still unable to assess the benefits of clinical audit five years after it was first set up in the health service, the NHS chief executive admitted last week….Some MP's expressed astonishment that the NHS executive has still not measured the outcome of the estimated 100,000 clinical audits carried out by Trusts, Health Authorities and G.P.s. A labour MP demanded to know how the NHS could justify spending £279m to date on clinical audit in hospitals – equivalent to recruiting 1,500 doctors a year.' (Health Services Journal, 21 March 1996).

This moment presented me with an opportunity to ***"liberate the petrified self of the audit culture"*** (cited in Stronach, 2002).

Already, in my role as a facilitator of healthcare improvement, I was beginning to ask myself this question, if organisations within the NHS are complex systems and much of the activity within the system is non-linear and unpredictable, should I be also considering the human or people aspects of the organisation and the relationships that individuals within the system have with each other rather than focussing, as I had been taught to in this role, on developing ways in which to measure outcome? The quality improvement activity that we had been involved in to date had not embraced this fact at all.

When engaging in the process of devising theatre from research and throughout the rehearsal process I would not have needed to ask this question, I knew the importance of relationship and interaction. As a theatre practitioner, educator and deviser I had practiced this for many years and yet I was insecure about my knowledge and experience within one context being applied in another context, in this case the NHS. I was

however, beginning to read others asking similar questions within the complexity field. Lewin and Regine in "Weaving Complexity", (2000), had also focussed on relationships and interaction and they call this 'relational practice'.

"Relational practice starts with you and how you interact …… It's a practice of developing personal awareness through reflection and action – an awareness of our impact on others and their effect on us, and being aware of the quality of relationship itself and taking responsibility for "it". If "it" doesn't feel right it needs to be addressed."(Lewin & Regine, 2000. p.306.)

I knew that I knew this and had practiced this and had developed, as a consequence, a range of intuitive and skills methodologies and approaches in the course of all the work that I had done. I was also at this time asking myself why are we so often working in a way that promotes key indicators to change that appear to be devoid of the dynamics of the people involved? Why were we no longer paying attention to the people who make up our organisations? Why did we only consider and value outcome as a measure of how good or bad the quality of the care we were providing is? I was beginning to address some of the answers to these questions by my engagement and consequent growing awareness and understanding of the different approaches from complexity writers and my embedded practical knowledge and experience as a theatre practitioner and educator.

We often look back in time and reflect on how much simpler life used to be and this is indeed the case, life in the past was much simpler. The shift from the industrial to the information age has led us to understand that life is now much more complex, all is part and parcel of a multitude of interwoven complex systems. Life in organisations has also become more and more complex with many managers and organisational leaders having to commit more and more time to their work life often at the expense of their home lives. As a consequence of this increase in demand they are

finding it more and more difficult to do their job without having to engage in a multi complex series of systems that are geared towards greater efficacy and an increase in productivity. As a consequence of the emphasis that is being placed on increased productivity and the reduction of waiting lists, all within a political context, very little of our time is spent on how we function on a day-to-day basis. Investing time and energy on developing relationships within clinical teams has not been very high on our list of priorities. In my experience we are now finding to our cost that not developing individual and team based relationships has a profound affect on the way care is being delivered to those using our services. A comment from a very senior surgeon at the end of one of my very early workshops for clinical leaders which focussed on relationships emphasises this point.

"I am a surgeon and when I have a patient on the table I can't waste time asking everybody for agreement or asking if they are all happy! I have to be decisive and act quickly. What I didn't realise is that I have been behaving that way in every aspect of my working life…I've been behaving in a terrible way towards the rest of my team." (Excerpt from my reflective journal, 2001).

Much of this experience I now understand is as a result of what has been the dominant management theory in our organisations. This affects the way we organise ourselves as professionals and also how we provide a coherent health care provision for the people who use our services. I now recognised the importance of moving away from our traditional management processes, processes based on the Newtonian and Descartes model of the machine. This model was first used to develop management theory at the beginning of the twentieth century and views management from an engineering perspective. This theory was developed by Frederick Taylor (1911) an engineer and it is this theory that is still alive in many of our organisations. This model works on the assumption that organisations

are machine-like and the way to solve large organisational problems is to break them down into smaller more manageable problems that are easier to solve. He advocated the treatment of employees as positive units of production.

"The work of Frederick Taylor, Frank Gilbreth, and hosts of followers initiated the era of "scientific management." This was the start of a continuing quest to treat work and workers as an engineering problem. Enormous focus went into creating time-motion studies and breaking work into discrete tasks that could be done by the most untrained of workers. I still find this early literature frightening to read. Designers were so focused on engineering efficient solutions that they completely discounted the human beings who were doing the work. They didn't just ignore them, as has been done more recently with contemporary reengineering efforts. They disdained them – their task was to design work that would not be disrupted by the expected stupidity of workers." (Wheatley, 1999. p. 159).

I have learnt that life in organisations isn't quite that simple and trying to solve problems in this way can often cause even greater problems than the one you started with. This also encourages us to surround ourselves with boundaries and to see these boundaries as places of severance rather than as places of dynamic interaction (Rayner, 2004). In my experience of working with process improvement teams over the years tackling one part of a system, working within a boundary, can sometimes result in chaos in the rest of the system. We experience the space between us as a separation, that which separates, rather than as in Rayner's, (2003), ideas of inclusionality, we might view this space as that which connects us to each other and indeed connects us to everything else.

This traditional way of thinking about organisations and machines also results in the development of hierarchies and a command and control way

of working. This is because it imposes compliance on us rather than including and relating to us. Traditionally we have expected managers to design the systems and the workers carry out the work. I have found myself in a role where I was constantly trying to bridge the gap between the two, at one level I was being asked to put into place new policies or strategies and at the next level trying to work with clinical teams who were desperately trying to make sense of these policies at the point of implementation. However, if we shift the way was see organisations from machines to complex, interwoven systems we can begin to better understand the need to approach change from a different direction. Complex systems are unpredictable as the individuals within the system have the freedom to act independently. If we recognised this, we can also see that these teams have the potential for self-organisation and need to have ownership of any changes that were required to their clinical and organisational practice.

Many of the health care professionals that I have worked with have been finding it difficult to embrace the drives and changes to healthcare provision that are required from a modernised NHS via the Modernisation Agency. The Modernisation Agency (M.A.) was created by the present government and was first mentioned in their NHS plan in July 2000. The NHS Modernisation Agency was set up to improve health and health care by working in support of staff and managers in the NHS alongside line management.

It has two core roles:

- To modernise services, particularly in improving services to meet the needs and convenience of patients to meet the aims of the NHS Plan
- To develop current and future leaders and managers for the NHS.

How is this different to my experience of the performing arts? In my experience the main differences are that here, people, narrative (storytelling), relationships and learning are at the centre of everything a performing artist does. The actor, dancer, musician, playwright, singer and the host of other specialist areas within the performing arts develop processes and techniques that welcome contradiction, uncertainty, novelty and spontaneity as an every day part of their professional experience. (Naidoo & Naidoo. 2003). Actors are trained to develop for themselves methodologies that fully embrace the use of insight and intuition in the development of practical analysis that they can channel back into the creative process. Dancers like actors are trained to develop techniques that enable them to reproduce fractals (dancers call them motifs) that are based on observed behaviours and relationships. Indeed all practitioners in the arts who retain a passion for their profession have well developed abilities to put complexity into practice in order to explore for themselves and consequently others.

In preparation for production performing artists display a practical knowledge of complexity that harnesses the individual and develops the team. Every time we go to the Theatre as spectators we experience this multidisciplinary teamwork and we witness a demonstration of complexity theory through art as the characters played by the actors recreate behaviours, values, contradictions and emotions that have been drawn from their observations and life experience. We see the end product of a long and sophisticated process that involves the continuing development of skills (their very own 'Plan Do Study Act' cycles), techniques and understandings that launches the creative practitioner on an uncertain journey that creates new challenges and learning for the performance team every time.

The creative theatre practitioner, like any other professional needs to ensure that as creative entities they maintain their abilities to tap into their creative potential and apply these techniques to the interactive work that they engage in through each production and processes of preparation for production. They 'play' through a series of games designed to explore different areas or concepts that involve people. They explore form and content and the relationship between the two in order to identify what would be the most effective relationship to communicate their work. They use improvisational techniques to explore their own constraints and develop new and innovative ways to create and problem solve. They learn to adapt, self direct and adopt change while pursuing the ideal that will always elude them – perfection; this nevertheless is the process of continuing improvement that is an integral part of the artistic experience.

Complexity theory encourages individuals to live happily within uncertainty. By bringing the creative arts to the health service I believe I have found a suitable methodology that has been developed specifically by using the creative processes to improve provision and bring a quality of interaction across teams and professions that enable new emergent cultures to occur in localised contexts. I now encourage people to embrace tension and conflict and uncertainty, as they are all part of every day life as well as professional life. Like many creative practitioners it is how well equipped we are to deal with the processing of them that matters.

Fritjof Capra, (2002), also refers to living and dealing with conflict and tension and uncertainty, particularly that experienced by those engaged in creative activity.

"The experience of tension and crisis before the emergence of novelty is well known to artists, who often find the process of creation

overwhelming and yet persevere in it with discipline and passion." He goes on to say that of course there are degrees of crisis and not all of them are as extreme but what they have in common is uncertainty. ***"Artists and other creative people know how to embrace this uncertainty and loss of control……After prolonged immersion in uncertainty, confusion and doubt, the sudden emergence of novelty is easily experienced as a magical moment."*** (Capra, 2002. p.118).

What I now had was an opportunity to bring this way of working into the mainstream of health service modernisation. Doing this I now understand would also help me to transform my embodied values into living and communicable standards of judgement by engaging in a process of accounting for myself to others as I engaged in a process of studying my practice as I ask myself the question, "How can I improve my practice?" and in doing so create my own living theory of my practice.

Back in Bologna we had the opportunity to talk at length about the Royal College of Nursing Leadership programme. Here they were trying to take a very different approach to the way in which they were preparing nurses for leadership. I described the way in which I believed that theatre games and exercises would be helpful in developing those skills. They were quite excited about the potential for working in this way and I was asked to put some ideas down on paper. They had referred to the workshop as a "visioning workshop". In this instance I interpreted this as meaning, to create an environment that encouraged the participants to think and act in a transformational way in order to imagine solutions that took them beyond their usual way of problem solving. This was my starting point on which to devise a whole day workshop.

Shaun and I, as always, worked very closely together devising a programme for the day that we hoped would achieve the potential for the

participants that we knew this way of working had. I knew that it was probably going to be quite a challenge to engage a group of people who have probably not been engaged in a creative way for many years. We would be demanding a lot from them throughout the day and we had to make sure that we created an environment of trust where individuals would be prepared to take risks and to expose themselves to a process that would challenge them. With all this in mind we carefully planned every step of the day in order to identify a process that would take them gently to a creative space that they were fully prepared for.

We approached the first half of the day in the same way as we would when working with a new theatre company at the start of an ensemble rehearsal process. The group need to be almost coaxed into the creative process and that is the function of many of the games in the early part of a workshop. It is important to begin to breakdown barriers and to build trust within the group if individuals are going to feel secure enough to begin to use their imagination. This is where our embodied knowledge and experience comes into play. It is very important to understand the relationship between the form and the content of theatre games to know what is appropriate for each group in order to be able to respond truthfully to their needs. Also the choice of games and exercises relies on an understanding of the groups' engagement. Theatre games always come with a set of rules. These rules are designed in order to create a specific dynamic relating to the purpose of the game. This gives structure in which the participants can funnel their creativity. The facilitator also has to have experience in 'reading' the group in order to be responsive and I rely on my knowledge of this now to lead from one exercise game into the next. It is only with experience of 'reading' groups in this way can I know how to respond and when to move the group into the more creative areas of improvisation and image theatre. If you do this when they are not prepared you are in danger of losing their engagement. As my knowledge

and experience has grown over the years of working with groups in this way it is possible to spend a whole morning with one group playing one game and yet another group will get through 5 games in the same time scale. As a facilitator I have to understand very quickly where this group is and where their starting point is, not where I think or assume they are but from where they actually are, they define the starting point by their commitment to engaging in the process.

In this our first workshop it was important to develop trust within the group so that the participants would feel comfortable with the more demanding tasks of the afternoon session. We also felt it important to introduce exercises that would explore the way they communicate and relate to each other. The playing of these games and exercises also demands the use of all of their senses; they are encouraged to feel, touch, hear, and speak in a way that would alert them to those senses in a more heightened way than is usual in our day to day lives.

Our plan was to also include image theatre and improvisation in the workshop. Image theatre requires the group to create a series of physical images in a montage style recreating a situation in an abstract way. In order to do this they have to first of all understand and reach agreement on how each of the parts of the image interacts and relates in order to recreate or 'codify' the situation. Having to critically reflect together in this way in order to reach agreement forces them to 'decodify' in order to identify the issues. They then have to change the image and create a new image showing how they would like it to look, which requires a 'recodification' of the situation.

"Individuals, who were submerged in reality, merely feeling their needs, emerge from reality and perceive the causes of their needs. In this way,

they can go beyond the level of real consciousness to that of potential consciousness much more rapidly." (Freire,1970. p. 98.)

Improvisation occupies a special place in the range of techniques that actors use. It is often used to help solve problems where conventional thinking particularly within a creative context is not working. It is also used to develop new ways of working that can be spontaneous and innovative. Through improvisation we create relationships with other improvisers that utilise our imaginations and explore the differences that exist in relating that leads to creative emergence. Improvisation happens without the use of complex structures and codes other than those which we bring as individuals. I now use improvisation extensively within my work in the health service to demonstrate how complex and unpredictable the human response is and how complex the behaviour codes that we use to determine our identity, status and emotional state are. Used together with the work of Boal and that of Freire we can clearly experience how difficult we find communication, relating and identity. We can discover things about ourselves as professionals as well as our personal skills. Placed in the context to develop team identities and the creation of multi professional interactive dynamics; discovering the complexity within this process is always a revelation where paradox is a constant practical feature.

Patricia Shaw writes;

….. practitioners in the arts have an acute sense of the paradox of 'being in charge but not in control' as we strive to play out creatively the evolution of our interdependence and conflicting responsibilities and aspirations, forming and being formed in the process. (Shaw, 2002. p. 117).

I recognised that this was an important skill for both managers and leaders within complex organisations like the health service to develop, to be able to be in charge without feeling the need to control. I also recognised what Patricia was referring to and this had also been my experience as a performing artist.

This was however, the first time we had attempted to use this process in an open and explicit way. We wanted to make sure that the leaders of this programme were clear and happy about what we were suggesting. We put together an outline for the day for the RCN team to consider. We wanted to make sure that we had agreement on the purpose of the day before we began to devise specific games and exercise and any other creative activity. In this way we would be sure that we were creating something that was in line with their needs at that particular time.

I talked at length to them about the group we were going to be working with and devised the final day to meet their needs at that moment in time. This particular group had already had an opportunity to engage in some creative activity and had requested more of this kind of work

The day of the first workshop

I can remember every little detail of the train journey to London to do this workshop. I was so excited and yet at the same time incredibly nervous. I had been building up to this moment for many years, I had worked long and hard to get to this point and yet here I was sitting on a train to London hoping I had got it right. When I reflect on this day now, I can understand why I was so nervous at the time and looking at the way the workshop was designed gives a clear outline of this insecurity. I had had an enormous struggle over the years since my return to the health service as I tried to engage individuals in multi-professional reflective practice. This way of

working is more routine within the nursing profession but even here the reflection is on nursing practice and not very often undertaken within a patient focussed multi-professional setting. My determination to create a workshop that was perfect is very evident in the way I have, against all my instincts, plotted carefully every step in the process. The design of the day was very linear and allowed very little room for flexibility. The difference between this workshop and current workshops is incredible, as my confidence in my embodied knowledge has grown. I am now more willing to allow my self to act on my feet in an improvisatory manner, engaging in a creative relationship with the participants. This way of working allows for a more dynamic relationship to emerge. This places me as a facilitator within what Bernstein (2000) calls the "Discourse gap", I refer to this way of working as 'being in the moment' and is a truer reflection of the way actors will work together in an ensemble manner. It did however take a few more workshop experiences for me to feel able to work in what for me is a more authentic and truthful way.

This first workshop was however a milestone in my development. The participants drifted in one by one as Shaun and I were setting up the room. We were a little concerned about the room we had been given to work in, it was a very grand but ancient Boardroom and in the centre hung a very impressive chandelier. We had planned quite a physical start to the day, which involved playing with a football, and we were worried that the chandelier would get damaged. This is an ongoing problem with the kind of work I do in the kind of settings I do it in; it is always difficult to find an appropriate space within organisations for people to come together in this way.

At the start of a workshop session we usually talk with the group about why they have come to the workshop and what their expectations of the day are. It is important to understand how they feel about being there and

so they are always given the opportunity to communicate their anxieties, to tell us what they feel. It is very unusual to find a group, who are completely at ease with the prospect of engaging in a creative session particularly when, and this happens frequently, they have been instructed to attend by their manager.

This is also the point where I am taking time to begin to read the signs that are coming from the group. I can really get a feel for how confident or insecure they are feeling. It also gives them an opportunity to begin to get to know me and what my expectations of them will be. This is the start of the building of our relationship, a relationship that requires them to begin to trust in me and in my skills as a facilitator. I will draw on my wealth of experience and knowledge of groups and teams and become who they need me to be at that moment in time.

The most common anxiety expressed by participants is in relation to role-play. This fear of role-play is quite often related to past experience and probably quite justified. I have been a participant in many facilitated workshops myself where role-play has been used without a real understanding of its function leaving participants feeling confused and concerned. There is also confusion between role-play and improvisation. The most important difference for me is that improvisation focuses on developing the relationship between the improvisers, where as role-play focuses on a task. Role play can also be experienced in a propositional way as the facilitator of role play usually assumes an impositional position by imposing roles and scenarios. When I use improvisation I assume a more inclusional role in that the process is one of exploration. It is really important when using creative techniques that the facilitator is experienced and fully understands what they are undertaking or you can turn individuals off all creative activity forever. This happens when facilitators are unable to read the signs and take individuals into exercises

that they have not been fully prepared for. I felt I needed to identify the skills I think you require to facilitate this kind of work in this kind of environment, as this role is crucial within the workshop. Shaun and I put together a list of facilitatory requirements to help others with this task:-

- A good working knowledge of health care organisations.
- Experience of working creatively and responsively with multi-disciplinary teams acknowledging boundaries and seeing them as places of dynamism and relationship.
- An awareness of inclusional multi-disciplinary approaches to clinical/medical practice.
- Practical experience and understanding of the dynamics of complexity organisations.
- An ability to develop individual perceptions through learning based on practical activity.
- An ability to demonstrate the nature and effects of group dynamics in pressurised situations.
- Experience of using creative 'transformative' approaches and techniques to support individuals and groups in their development.
- An ability to use creative problem solving skills and techniques.

As well as identifying insecurities within the group we also encourage participants to express their expectations and these are also very illuminating. At the end of the session we always revisit these lists with the group and talk about whether they are still anxious and whether their expectations have been realised. After 2 or 3 workshops Shaun and I began to include our own expectations and insecurities. We started to do this because throughout the workshop the participants work together in a very truthful way exploring their values and relationships and are often challenged and encouraged to take personal risks we also felt it important to include ourselves as apart of the experience. We have also found it

important to challenge ourselves within the workshop setting as well. Participants concerns have presented us with a pattern that reflects my concerns with how we do not encourage ourselves to be creative. Although the participants had been told that they would be engaging in creative activity they had very little idea what to expect from the workshop. They also told us that their previous encounter with 'creativity' had left them wondering what the purpose of it had been. They had enjoyed some of the activity but were finding it difficult to relate this to their day-to-day roles.

What are my worries about the workshop?

Don't want to do role-play
Might make a fool of myself
I can't act
I hate doing things in front of other people
Done this before and it was a waste of time

What are my expectations?

Probably going to learn how to juggle
Going to have to do role-play
Don't have any
Don't know what to expect

What do I want to happen?

I want to improve how I communicate
Want to work better in our team
Want to have fun
Want to do my job better

I want to learn something new

I discovered going through this process that there were some underlying anxieties which mainly came from the fact that they had been given very little information about what the day would involve although we had gone through a lengthy process of finding out about the participants and the environment they came from. This I now understand is an example of the kind of impositional logic (Rayner. 2003) that also prevails within education and development. We impose our ideas on other people rather than engaging them in a relationship that allows us to be included in the process. This is not, however, about gaining consensus but rather an opportunity to hear all our voices, even though these voices may hold different and diverse opinions.

This group were in fact much better informed about the workshop than many of the other groups we have worked with since. The participants here had been actively engaged in deciding what their learning needs were and the organisers had tried to accommodate those needs. It was evident that they had developed a clear and unhindered ownership of their learning and learning need. This was indeed an integral part of the leadership programme that they were part of. This enabled their participation in their workshop to be underwritten by a commitment to take some risks in the pursuit of the discovery of new aspects and perceptions as learners and leaders.

In subsequent workshops we have met participants who are very anxious about what the workshop will demand from them. They are sometimes sent along without any prior information at all, just told to go.
This says a lot to me about healthcare organisations and the way in which the dominant style of management is very often still one of command and control.

Even when you come across a healthcare leader/manager who is forward thinking enough to be inviting us into their organisation, there is still very often a gap between their thinking in relation to transformational practices and their behaviour. This is one of the themes that we explore in depth in many of the workshops, the theory/practice gap, it is very often a great surprise to participants that when they begin to work under pressure within a group they do not behave in the way they think that they behave, or are perceived to behave by their colleagues. In the day to day life of organisations we pay little or no attention to way we relate to each other and the impact we can have on each other.

I remember as a student actor how liberating it felt to work with a group of colleagues, recreating painful or stressful events and having the power to begin the process of changing the situation. The act of recreating a picture or montage for image theatre in this way requires the group of individuals to work together in a certain way. There has to be clear communication, trust, and co-operation in order to create the picture in the first place. There is then the requirement to analyse and decide together on a solution to the problem and this requires an inclusional way of working. The very fact that the recreation of the scenario requires engagement at a creative level often results in the discovery of new ideas that would not have been considered. As this process also acts a leveller, individuals who are often unable to contribute new ideas find that they now have a voice that is being listened to. This process can be a very empowering process.

The day itself progressed very well, the group were a little tentative at first but they very quickly became engaged in the work. What was exciting for me was the way in which the programme we had put together had real resonance for them. They were able to relate their creative activity back to the workplace. They explored areas of their working relationships that

they had not explored before and using a creative process that was new to them. They also had a great deal of fun and I believe that humour is an important part of this process.
We also asked for them to evaluate their experience and their evaluation of the day is included in Appendix 5.

What did I learn from this first workshop?

When I was asked to consider designing a 'creative' workshop for clinical leaders I was a little unprepared for the direction that this was going to take me. I was very excited to at last have the opportunity to devise something that I believed could have enormous potential to improve services for people using our healthcare systems. I also knew that I was walking a precarious tightrope and once halfway across I had to commit myself to getting to the other side safely. Why did I think I was taking so much of a risk? This feeling comes directly from my passion for my craft. I truly believe in its transformational ability but I am also a realist and working within a system that in my experience is often based on positivism and reductionism. I knew that I was going to be facing many cynics in the workshops and I wanted to make sure that every step was carefully planned and that I was also able to present an evidence base for what I was doing, trying to impose order on disorder. I now realise and understand that I do not have to do this in this way. ***"Hope of such order is fantastic rather than realistic. But it is sold as a New Realism (evidence based, effectiveness-driven, improvement-led). Each succeeding 'paradigm', is trumpeted as the final resolution of epistemological crisis, the advent of Science At Last (e.g. Reynolds & Teddley, 1998; Oakley, 2001) in a world grown increasingly unstable and unpredictable***. (Stronach, 2002. pp.110-137).

This really goes against who I am and the way I work. I am intuitive and sensitive to other peoples needs, both of these skills are essential to the kind of work I am engaged in and they are both skills that I have learned and developed. In the beginning I was unable to allow myself to rely on these skills and my embodied knowledge of my area. What I now understand is that here I am applying an impositional logic to my creation of a workshop; with all the best will in the world I am imposing my own discourse onto the content of the day. I do not, however, deny the existence of my discourse but rather I attempt not to impose this discourse but hopefully allow it to inform my practice. I am also aware that at the time this was probably the only way I could introduce this way of working into this environment. I am now much more able and willing to acknowledge my embodied knowledge as a facilitator and try to create a much more inclusional environment which allows me to respond to the participants and they to me in a much more organic process.

Inclusional roots

When I first returned to the health service I was not planning to stay for very long. For me it was really just a stopgap before I returned to working as an actor again. In my role as clinical audit co-ordinator I was able to develop my understanding of life within our health service organisations. I was also given a very difficult task and at first I was unaware of the difficulties involved. I was trying to encourage individual healthcare professionals to develop their intuitive ability but they were attempting this in an environment that was demanding throughput and outcome. I was able to engage some teams in multi-professional activity but again the work that they were doing and the improvements they were making to their practice were being overlooked by the organisation. I can remember presenting the results of a project I had been working on with the school

nursing service. They had been working in schools to try to improve the diet of the pupils in a particularly run down area, this is an issue that is still very pertinent. It was a fascinating project that included the school nursing service but also the children themselves and the local community. The team were successful in implementing a new menu for the school canteen and had been able to introduce a healthy eating programme into the school curriculum. The school nurses were justifiably very proud of their achievements. The school nurse and myself were presenting the findings to an audience drawn from all the professional groups within the trust and one of the doctors was waving his arm in the air wanting to ask a question.

"This is all very interesting and fascinating, but are your findings statistically relevant, are they generalisable?"

We took one look at each other and we froze, I didn't know the answer and neither did the school nurse. I replied truthfully that I didn't know but reminded him that this was an audit project and not a research project and that there is a distinct difference. His response was that he knew that and that as far as research was concerned he valued the findings but most audit activity was a waste of time. I felt very ignorant at that point and I resolved that if I was ever going to be able to engage individuals like him I really needed to be able to provide him with an answer. I had to be very confident in what I was doing in order to gain the trust and respect of the influential players in the health service if I was ever to persuade them to work in a creative way. I decided to look into the possibility of undertaking some training in research methodology. The following autumn I enrolled at the University of Bath and became once again a student. This time I was studying an MSc in social research. I didn't know it at the time but I was heading straight into the world of positivist quantitative research. This world believes that knowledge is fixed and

objective and there was little space for words such as intuition. I had to undertake 2 major pieces of research one qualitative and one quantitative. I chose to tackle the quantitative research project first as I thought this would be the one that I would find to be the most challenging.

The research itself was fascinating and I learnt a lot that I could incorporate into my role in clinical audit. I undertook a national survey of all clinical audit co-ordinators working in NHS Trusts in England. I built up a database of ethnographic evidence. There had been a lot of criticism that many of the individuals employed in the field of audit were under qualified for undertaking what was now being seen as a change management role. They were having to take the blame for much of the perceived failure of clinical audit. The picture I built up was very different. What my survey told me was that most of the clinical audit co-ordinators were in fact very well qualified; most of them were either professionally trained, nurses seeming to be quite a popular group, or they had undertaken a degree in a relevant subject. What they were saying was that they were able to do the job but that they were often placed too low down in the hierarchy to have any real effect or influence any change. I also asked them to answer what they thought the barriers to change in their organisations were. A great number of them (86%) said that when they were undertaking multi-professional clinical audit the doctors were not participating so when the audit identified the need for a change in practice there was no ownership from them of that need to change. As the doctors were very often the holders of power within the team their disengagement prevented any change from taking place. The findings from this piece of research were very useful to me in my day-to-day work in the clinical audit department. I was also very surprised at how able I had been in undertaking the research and writing a report.

The second project was the one I was really looking forward to doing. This time I used grounded theory to analyse the data I was collecting over a period of time. Grounded theory was developed by Glaser and Straus (1967), Corbin and Straus (1990) and by Straus (1987). In grounded theory the researcher does not begin the research with a preconceived theory. The theory emerges from the data the researcher collects.

"*Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action."* (Straus and Corbin, 1998).

I was gathering evidence from a healthcare community, both primary and secondary care, to build up a picture of how they were preparing for and implementing a structure for clinical governance. As I did not have a theory in mind but had a real passion for finding out how individuals were putting together a system to deal with clinical governance, grounded theory seemed to be the most appropriate methodology at the time. Again the research findings were fascinating and I was enjoying the process but I was unable to find any support from the Department of Social Science. When I handed in the first draft of my report I was in for a huge shock. Without any support in this methodology I had used my intuition and instinct to interpret the report and my research findings. I had written the report mainly in the first person. This was not acceptable and I was asked to rewrite the report. I was told in no uncertain terms that they were not interested in what I thought or felt. I as the researcher should remain objective and take 'myself' out of the research. In that moment I felt the whole weight of the academic institution on my shoulders. It just didn't make sense to me but was another example of the dominant positivist theory making it impossible for me to legitimise what I was doing. For several days I was in a panic, I had completed my research and I felt that the findings were very important and useful. My confidence also took a

huge blow but with a lot of encouragement from Shaun I got on with the process of rewriting my report in the third person in an objective way, but what I would claim is that this report, the one that was acceptable to the academic institution at that time, was lacking. It was lacking in passion and soul and all the other things that I had brought to the research – I didn't like it. I am not arguing in this instance that passion and soul should replace science, but rather that they could be used together and complement each other. This was my first experience of the so called paradigm war between purists of either qualitative or quantitative methodologies. A feature of these wars has been a focus on the differences of these methods which has resulted in two research cultures ***"One expressing the superiority of 'deep, rich, observational data' and the other the virtues of 'hard, generalisable'….data"*** (Seiber, 1973. p1335.) My preference as a researcher is to be able to draw on both methods as appropriate rather than having to opt for either or. This feeling disappeared for a while when I graduated, as a scientist, I was so proud of myself.

When I handed in an outline proposal of an action research project I wanted to do as my PhD Thesis I was also unprepared for the answer. I knew that action research was the most appropriate methodology for the project I wanted to undertake. I also wanted to make sure that I had a supervisor who was an expert in whatever methodology I chose but I wasn't sure how to find one. I rang the switchboard at the University of Bath and asked to speak to someone who knew about action research and I was put straight through to Jack Whitehead. Jack's response to my out line was.

"***This is very interesting and I would like to work with you on this. Only one problem with the proposal, where are you? I can't hear your voice***

in here at all. There is no 'I'. You need to find your 'I' and get it right into your work."

I was amazed and it was at this point that with Jack's support I began to put back the passion into my academic writing and find again my confidence. Undertaking this first workshop in the way I did also enabled me to share my passion and myself in a creative way. It also refuelled my confidence and enabled me to go forward and further down this creative pathway.

Following this first workshop I have been able to build on this experience and have developed and undertaken a wide variety of workshops with multi-professional healthcare teams both in the UK and across the world. There are several that stand out as having played a significant role in both my learning and the learning of the organisers and the participants.

Creative workshop for an Acute Trust

The first of these was held for an acute Trust but the group we worked with came from the wider healthcare community and included representatives from social services and the ambulance service. We had been asked to do the workshop by the human resource team as part of their ongoing professional development. They were also interested in testing out some work they had been doing with the team using Meredith Belbin's team role model. This is used widely in organisations for employment and team development purposes. In the first part of the workshop the human resource department wanted to undertake the final part of their Belbin assessment and give some feedback to the team on the outcome of that assessment.

Meredith Belbin has also produced guidance on what combination of individual roles you need to have an effective team. What the human

resource department were hoping was that the participants would display their Belbin 'type' as they participated in the workshop and that by doing this they would be able to see how useful the Belbin process was. (Meredith Belbin's grid is attached in Appendix. 6.)

In this workshop we would be starting off in the same way as in previous workshops by building trust and developing creative energy within the team to get them to a point where they would be able to engage in a devising and performance exercise. In this way the human resource team were expecting to see the behaviours identified by the Belbin session in action. The teams were firstly put into 2 separate teams, put under pressure to be creative and perform and then to work together again in a creative capacity.

The aim of this workshop is to bring together a multi-disciplinary group of people who would be exploring, through a creative process, the dynamics of team work, team building, group interaction, problem solving, communication, advocacy and leadership.

The group were split into two halves and each was given the same objective but with significant differences. The objective was to produce a small 'theatre' performance for the other group. Both groups had their own facilitator assigned to them who was also able to offer additional theatre expertise and support (if requested).

An additional facilitator, one of the Human Resource team, was also available to offer support to both groups as well as to note the development of the dynamic as the process unfolded. This facilitator also led the debriefing session at the end and it was their intention to draw on any data from the preliminary Belbin assessment within the debriefing session.

The Story

Each group was given the same story upon which to base their performance. The story is essentially a tragedy involving a simple narrative. Each group was given a different approach for the delivery of their theatre piece. One group used a different form of theatre than the other.

Devising

The groups then engaged in the 1st stage of the Theatre workshop. They were asked to devise a performance using specific criteria.
It was this process of devising that would enable the teams to be formed and the team dynamic to develop. Particular emphasis during observation was being given to how well the group interacts. They were also given a set of questions to ask themselves as they progressed through the exercise.

1. How creative and imaginative are they at finding solutions to the task?

2. In what way does each individual make a contribution to both the task and the dynamic of the team that they belong to?

3. It will also be worth noting any reticence at having to take the personal risks to perform or try out new ideas through the rehearsal process.

4. How do they handle the specific brief that they have?

5. How well do they listen to each other as the process unfolds?

6. What kind of rationale dictated the decision making process?

7. Who led the group, if anyone?

8. How do/did they feel about testing their work through a performance?

Performance and Preliminary Debriefing

Once the two groups had performed their short piece a comparative debrief took place. The aim of this debrief was three fold.

1. To celebrate their achievement

2. To re-enforce team identity via the original brief.

3. To highlight the merits and differences between the two pieces of work.

Stage Two Outline

After the 1st performances and initial comparative debrief the groups were merged. They were then asked to carry out the task once more and were given a new brief designed to create a degree of conflict between the two old groups. Despite this they needed to continue to work together in order to complete the task.

<u>The workshop</u>

This workshop was a very interesting one for me particularly with its focus on teams and group dynamic. This was also a smaller group than we usually have, there were 10 participants altogether so we worked in a much more intensive way. They were also a very diverse group which included members from each clinical group and also representatives from social services and the ambulance service. This group crossed the traditional boundaries of health and social care. What struck me about this particular group was their commitment to each other and to the workshop. They engaged with each exercise with incredible energy. They

contributed and challenged at every opportunity and they demonstrated a highly developed level of insight throughout the debriefing sessions.

When they split into two groups to tackle the devising of the theatre piece they instantly became competitive. What was more interesting from the point of view of the human resource individuals was that as they became more and more focused on the task and the pressure began to build their behaviour started to change. Each group self organised and in each group a leader emerged and took on the role of director. Someone else from the team became the creative energy pushing the storyline forward and in each team another individual took on the role of sorting out the fine detail focussing on the nitty gritty and keeping them to deadline. As they were such small groups these individuals were taking on these roles at the same time as being involved in the performance. The next task was even more interesting from a group dynamic perspective. The two groups had very quickly formed a strong identity and had developed relationships with each other. They found the merging of the two groups very difficult to deal with; they were reluctant to 'loose' their separate group identity and clung on to this for as long as they were able to. As a consequence roles within the new group were not clearly defined and they found it very difficult to focus on the task and were still maintaining their former identity and behaving still in a competitive way.

I believe that this behaviour has very significant lessons for working in organisations within the National Health Service. In the final debriefing session of the day the participants were expressing the view that it is not surprising that many teams within the NHS struggle when they have to contend with so many reorganisations as they very quickly lose all sense of individual and team identity. The process of enabling them to develop relationships with each other in their second team had been rushed and they had ignored the need for them to consider this. They expressed the

opinion that this was very similar to their work experience and they could identify that this could have a negative impact on the quality of their work.

It was also very significant for the Human Resource Department who then compared their individual team role in the activity with the role that had been identified by the Belbin exercise. In all but one occasion the roles were different. The group felt that this was because we, as individuals, are unaware of the way we behave particularly when we are under pressure. We are very often unaware of the way in which others experience the way we relate to them. The way we think we behave/ communicate/ relate is often different to the way others perceive us to behave/ communicate/ relate. This is why the improvisational work can be so significant in the development of identity and relationships and improve the way in which we communicate. In an improvisation we will take time to explore behaviour, both our intended behaviour and the perception of others of our actual behaviour. This very often leads us to develop insight into the kind of patterns of behaviour that we fall into, especially when under pressure and the impact that this can have on the people working with us.

Working creatively with healthcare teams

The other workshop that I believe was significant in the development of my practice was a workshop created for mental health service managers. The Modernisation Agency (MA) of the National Health Service has been developing a booking system to allow for more flexibility and choice for patients. The scheme, originally known as ABC or Access, Booking and Choice, allows patients to book their own appointment whether this is for a routine appointment or for a hospital admission. The scheme originated in the acute hospital sector and is acknowledged to have played a significant part in reducing waiting lists and also reducing the number of

missed appointments as people are able to choose their appointment date. Introducing a booking system requires more than just introducing a computerised system. The scheme has meant a change in the way hospitals plan routine work and has often been a challenge for those people who are responsible for making it happen within the hospitals. It was now time for the scheme to be introduced into the mental health services. Mental health were not very happy about this, they of course agreed with the principle of more choice and flexibility for patients but they felt that they had been handed something that had been developed for an acute sector and they were having to make it fit into their services and that this was inappropriate. There was also a feeling that once again mental health was being treated as an after thought and as a consequence the managers introducing the system had met with a lot of resistance from the clinicians.

The booking team had organised a day to bring the mental health service booking mangers together to try and find a way in which they could move forward. The team who were organising the day had expressed to me that they really understood and had sympathy with the problems they were having in mental health. They wanted the participants to identify the issues and to make suggestions as to how to redesign it for use within a mental health setting. They really were sincere in their desire to listen to the mental health teams. Their concern was that the participants would be so frustrated that they would use the day negatively and their one opportunity to influence the system in a real way would be lost. Their request to us was to create something to start the day off that would shift their negativity energy into a positive and creative energy and enable them to focus on redesigning the booking process for mental health.

This was again a shift in the focus of the function of the workshop and required a significant amount of thought and design. We agreed that it

was very important at the start of the day to acknowledge the feelings of the participants. We did this by using a chat show format that we have developed to encourage the questioning of 'experts' in a very supportive and truthful way. The organisers became the 'expert guests' and the rest of the group the audience, who asked questions in an informal setting. This process is facilitated and both parties encouraged to be as open and honest about their worries as they possibly can. This process relies very heavily on the ability of the facilitator to pick up the issues and to read the subtext and to respond in a way that enables difficult questions to be addressed. This question and answer session becomes more of a supported conversation with the facilitator acting in an advocacy role. The main points are recorded and at the end of the day the format is repeated and we ask whether we really have addressed their issues in an acceptable way. Chat show part one was followed by a series of exercises that first of all focussed on them as individuals. We started off with a relaxation exercise the purpose of which was to enable them to unload some of the baggage that they had come with. This was followed by a gentle warm-up, firstly at an individual level, concentrating on both the body and the voice and then moving into a team based creative activity. It was important from my point of view that the organisers, all of them very senior policy makers, were part of this activity. They were of course rather reluctant at first and needed some gentle persuasion. Their participation also had a very positive effect on the dynamic of the group as a whole. They were all having to work at the same level, there was no command and control and as a result some very positive self-organisation and emergent behaviour resulted. The group was then able to tackle the day's task in a very upbeat and positive frame of mind. They had developed a relationship with the organisers that was based on trust and clear communication and felt that a more level playing field had been created. At the end of the day we organised a second chat show with them following a similar process as the morning's session but this time

addressing the issues that they had raised in the earlier session. The feedback was excellent. This potentially very negative group who had approached the day wanting to have their say and make their point, felt that they had been listened to and had been able to change the way that booking was being introduced into their services. This demonstrates a significant move away from imposition to inclusion. Most importantly they reflected that if they had been told that they would be engaged in this kind of creative activity at the beginning of the day they would have been very cynical.

Learning about learning from playing creatively.

Over the last couple of years I have been involved in the development of many different kinds of creative workshops that have been undertaken in a wide variety of settings both in this country and in many other countries around the world. Each new workshop has resulted in me taking a step further into the use of creative techniques as my knowledge and confidence has grown. I am always encouraged by the level of engagement in the creative activity by some of the participants in these sessions, some of whom have not been involved in this kind of work before. I am now much more able to allow myself and my intuition to take the group in the direction we need to go. There is often an improvisational nature to the content of the workshop which develops from the input of the participants. Although each group is very different in the way it engages creatively I have been able to identify some themes that have reoccurred throughout the workshops. One game in particular which we call "A which and a what" has identified some important issues. In this game the participants create a complex system, they build up the complexity of the system gradually by a series of instructions issued to them by the centre in a very command and control way. It very soon becomes apparent that the system is flawed and the more they work to

make it work, following directives to the letter, the more difficulty they experience. The amount of information about the group that this exercise illuminates is extraordinary. One of the most significant points that it brings to our attention is the way in which the different professional groups appear to react to the system. We have played this game with 100's of groups and the same behaviour happens each time we play it. Some, when they recognise that the system isn't working break the rules instantly and change it. They just decide what they want to do and do it, this is usually without consultation or agreement with others and you end up with many different individuals doing many different things all at the same time. Others put all their energy into making the system work, follow all the rules and do their utmost to make it work, even when they know it can't. In this instance they work more as a team, supporting and helping each other in order to get the system to work. This speaks volumes to me about the different ways in which we educate healthcare professionals. This insight into the difference in behaviour is significant for healthcare leaders when we are working with multi-professional groups in order to introduce change. Healthcare leaders need to have an understanding of how different the behaviour of different professional groups is displayed in order to work with them in multi-professional contexts. This is particularly relevant in the current climate of intense change. It is also further evidence that developing the creativity of the team can have an impact on the way in which members of the team develop their individual and group identity and the way in which they relate and communicate. What is also important is that this exercise opens up a conversation about these issues very quickly. The participants are immersed in an experience which they are encouraged to translate into their work and life experience and because they are in an experiential moment the conversation is influenced by experience in the moment. An extract from an evaluation by a General Practitioner of his experience following a creative workshop also indicates that engaging in a creative

process can have an impact of the development / transformation of our practice.

I work in a general practice in Lambeth. In the past we have employed Marian to do work with all 20 members of the practice to explore how we might improve the way we work and relate together

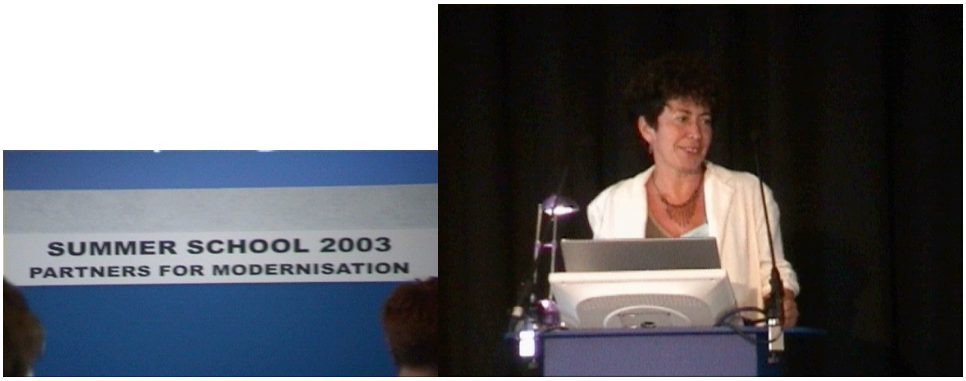
Historically there has been little history of the people spending time together. This is partly to do with the architecture of the building which makes it difficult.

Following the first half day session we did. We had a further afternoon of Practice development. We have one large room which traditionally has just been used for the baby clinic. From the energy of the morning, we stripped the room and turned it into a place where we could meet for a coffee break every morning. This had never happened before. We chat about patients and Each other and share problems. I make a very direct connection between the creative work we did with Marian and the capacity for us as a group to find creative solutions to improving the way we work. (Dr Alasdair Honeyman, 2003).

Since I first began to devise and deliver these creative workshops I have extended my own knowledge and understanding of my practice over and over again. The process of undertaking living theory action research at the same time has also lead to me having a greater understanding of my embodied knowledge and in what way my values are directly influencing the way in which I practice. When we evaluate the workshop at the end I am able to ask myself if I have been able to communicate my values through the workshop work. This enables me to reflect on my practice and to know where my practice should improve.

I am also beginning to sense a sea change in the way other people react and respond to this kind of work. The suggestion from me to work in a creative way was often met with a very reluctant response. In just a few years this has changed and my intention to work in a creative way now appears to be more acceptable in complex organisations where more emphasis needs to be placed on the relationships of the people involved in the organisation. I was approached in the summer of 2003 by Kate Harmond who was clinical director of the Modernisation Agency to contribute to their annual summer school for clinical leaders. We had contributed to this workshop the previous summer and following this have been able to contribute to the national modernisation agenda in many ways. (See chapter 8. 'Using the performing arts to encourage emergence.') On this occasion when I asked Kate what she would like us to do she replied, ***"Oh just do your thing, whatever you decide to do will be fantastic."*** The amount of trust embraced in this response holds huge significance for me and my practice. It also allows me to practice in a responsive and improvisational way because individuals like Kate know that my experience and my embodied knowledge mean that she has been able to place trust in my practice. In a recent conversation with Kate about the workshop and what developments had been made following it she also added the following comment.

"What you both have is an amazing ability to create an environment, a space, where people feel able to take significant risks, but you hold that space in such a way that they never feel at risk, and they never really are at risk."



Kate Harmond opening the 2003 summer school

In April 2004 I was appointed as a National Service Improvement Lead by the National Institute of Mental Health in England (NIMHE) which is the mental health arm of the modernisation agency and is part of the new Care Services Improvement Partnership (CSIP). In my new role I have been asked to work with particular mental health organisations who are pilot sites for the development of mental health improvement partnerships to encourage a more creative, inclusional and responsive way of improving services.

The significance of the DVD I have created as a contribution to this thesis has been emphasised in other chapters, and particularly in ***using the Performing Arts to Encourage Emergence.*** I was also keen to include some of the creative engagement work in this DVD. I have decided that this is inappropriate to do so because of the sensitivity of some of this work and the risks individuals sometimes take in the workshop. I did however want to be able to share the joy and passion that I feel when working in this way and also when engaging creatively with other people. In the final chapter of my DVD I have tried to communicate this passion and share the life affirming energy that keeps me working in this way. I have had the opportunity to work with other people who are working in a creative way throughout this period. We get together to share what we have been doing, challenge each others perceptions and develop our

knowledge and understanding of working creatively. These people have allowed me to use some of the footage recorded at our workshops. Intertwined with this are images of the people I have worked with who have contributed to my development from all over the world. What I hope to communicate is that my practice is continually developing as I engage in creative, pedagogical and responsive relationships with the people who I have had the privilege to work with as we all try to improve our practice and together co-create a health service that is inclusional and responds not only to the needs of the healthcare professionals but also to the needs of the many people using the service.

Throughout this period I have been part of a collaborative inquiry group who were commissioned by the Nuffield Trust. The outcome of this inquiry was published as a strategic paper and is attached as Appendix 16. (Swallows to Other Continents. 2004). This report sets out the strategic issues and recommendations for promoting the use of creative arts in healthcare. It has also prompted a scoping exercise across mental health services that has just begun. The purpose of this is to build an evidence base of the effectiveness of the creative arts as a tool to improving the experience of mental health service users. I am confident that the work that I have engaged in will make a significant contribution to this activity.

This chapter, alongside the visual narrative, communicates how through the use of creative workshops for healthcare practitioners, service users, carers and managers, I have been able to clarify my passion for compassion as it is emerging in my practice.

The following chapter builds on this as I show how the use of theatre for development re-emphasises the importance of a passion for compassion in my practice. It also supports the visual narrative as I demonstrate how this is sustained this by living this value in my practice.