Creative Arts, Healing and Recovery

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Mental Health, Transformative Learning, and Creative Practices: Shaped by Time, Altered through the Arts

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ABSTRACT

This paper introduces a selection of research articles, reviews, and studies on mental health and stigma, transformative learning theory, and arts-based inquiry. Research is limited predominantly to the last twenty years with a strong presence of ProQuest and CSA Illumina/Sage databases as qualitative assets. To set context, I begin with a brief overview of Canada's efforts to reduce stigma and acknowledge the existence of both structural and individual discrimination towards people with mental illness. Discussion within this paper uses arts-based pedagogical approaches, including Eisner's (2008) concepts of productive ambiguity and Lawrence's (2012) concepts of embodied knowing to explore the potential for transformative learning for participants in arts-based community programs. Key to their transformation is disclosure in a supportive environment where they can make art as adults with mental illness and express their cultural identity. Possible benefits toward building a more resilient life for the artists and those who share their experience are considered.

Context

In any given year, one in five Canadians experience a mental health problem or illness (Canadian Mental Health Association website retrieved April 14, 2018). According to the World Health Organization (WHO), the most important barrier to overcome in the community is the stigma and associated discrimination against persons with mental illness (WHO, 2001). Many people who have experienced mental illness report that discrimination causes them more pain and suffering than the illness itself.

Numerous sources confirm the existence of both structural and individual discrimination towards people with mental illness (Corrigan, 2003, 2004). In a compilation of more than 10 years of research on mental health and discrimination, negative attitudes were found prevalent within the general population, including health care providers, and internalized by people with mental illness, thus affecting their recovery (Hansson et al., 2011). Stigma carries with it marginalization, which can cause impaired self-esteem, reinforce social belief in low expectations for improvement, and impede social integration. Stigma cuts into the heart of recovery because it takes away hope and this gets in the way of an individual's discovery and rediscovery of personal strengths and purpose (Onken et al., 2007).

In the framework for "Mental Health Strategy for Canada: Toward Recovery and Well-Being" (Mental Commission of Canada, 2014), a state of well-being is defined as a state "in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community". Additionally, I include the notion of recovery defined as "the possibility of achieving a meaningful and more resilient life irrespective of mental health disabilities" (Crawford et al., 2013).

The Mental Health Commission of Canada (MHCC) was established in 2007 to address the lack of national focus on mental health. In 2009, the MHCC launched *Opening Minds*, a systemic effort charged to reduce discrimination associated with mental health. The Opening Minds Report (MHCC, 2018) surfaced many findings, including that there were hundreds of grass roots community-based education programs involving adults with mental illness already happening across Canada. It confirmed contact-based education as key to successful anti-stigma programs (p. 35). The report further revealed, a focused community-based approach is cost-effective, sustainable, and capable of getting the results needed—changes in Canadian attitudes toward people with mental illness (p. 3). To take action toward cultivating an environment where people living with mental illness are

treated fairly and have the same opportunities to contribute to society, as anyone else, several priorities need to take place; one priority identified is improving knowledge and fostering community collaboration (MHCC website, retrieved January 19, 2018).

Arts-based community programs exist in many forms, most often in informal settings (for example, creative writing groups, drop-in art centres, community studios, and so on). In a common approach, these participatory venues encourage the arts as an activity of expression with emphasis on involvement of people within the community (Strand et. al, 2003. p. 95). This, in turn, can provide a space for learning to happen and can surface opportunity to develop connection through relationships and group interaction. Arts-based community programs can provide ways to break down social barriers, express and understand experience and emotions and help build or rebuild identities and communities (Devlin, 2009; Secker et al., 2007). Beneath the recovery process is "a need for respectful engagement, presence, and approaching individuals with a shared humanity" (Delaney, 2012, p. 334). Arts-based community programs may be one setting that can bring about the process of expression, meaning making, and hope.

Engaging in change efforts, whether personal or social, requires people to critically examine present conditions and imagine creating better conditions. It starts with critically questioning the integrity of our deeply held assumptions. This is of particular importance for adults with mental illness where discrimination has been a constant reality. Many arts-based community programs take on a position of developing skills and encouraging dialogue to disrupt perceptions of passively accepting old ways of thinking that normalize stigma. Arts-based community programs encourage learning and growth in a setting where individuals with mental illness can make art as adults and feel supported in exploring new ways to reflect on what they can do. A review of transformative learning theory provides further insight into how adults experience fundamental changes in perspective.

Transformative Learning

Transformative learning (TL) theory was introduced 40 years ago, to help explain how adults interpret their world and make sense of their personal life experiences. TL theory was introduced in Mezirow's (1978) studies of women returning, after an extended time out, to postsecondary study or to work. Mezirow

interviewed 83 women and described the dramatic changes in their self-perceptions as they began to redefine their identity and question culturally prescribed assumptions of what their role should be (Magro, 2001). This perspective transformation was complemented by the women's movement of the 1960s and 1970s which helped women feel supported in examining their lives (Magro, 2001) Mezirow concluded the participants had undergone "personal transformation". According to Mezirow, the human condition is defined by the need to connect meaning to life experience. TL happens as the individual forms and reforms this meaning. It may be triggered by a sudden or major change, or it may be incremental and involve objective task-oriented or self-reflective reframing" (Mezirow, 2009, p. 23).

Adulthood is a time where we recognize that not everyone experiences the world the same (Carpenter & Mojab, 2013). It is a time for critically exploring, questioning, and rethinking assumptions about oneself and one's world view and integrating what we learn into larger context (Magro, 2001).

Over the years, TL theory has evolved into a comprehensive description. Today, the Transformative Learning Centre's approach is grounded in hope and described as "experiencing a deep, structural shift in basic premises of thought, feelings, and actions. It is a shift of consciousness that dramatically and permanently alters our way of being in the world … TL has an individual and collective dimension and includes both individual and social transformation" (Transformative Learning Centre website, retrieved January 19, 2018).

Transformative learning gives the framework for describing how adults learn best (Cranton 1994). Critical exploration is an approach that can happen during the learning process to encourage belief in one's ability to affect change. Community organizations are increasingly using the arts as a tool of adult education with marginalized groups to promote individual and collective empowerment (Clover, 2006). What does creative practices in the arts provide that which could spark self-reflexivity and learning?

Empowerment through Creative Practice in the Arts

The arts help us learn to notice our world and can also enable us to experience vicariously the experience of others. As Eisner (2002) explained,

> Work in the arts is not only a way of creating performances and products; it is a medium of education—a way of creating our lives by expanding our consciousness, shaping our dispositions, satisfying our quest for meaning, establishing contact with others, and sharing a culture. (p. 3)

The arts slow things down affording time to reflect, dialogue, and enable discernment. We develop habitual expectations based on past life experiences and the social context in which we live (Taylor, 2009). Examining, questioning, and revising these perceptions can create a space for new thinking. The arts are not about giving answers; they are productive, generative, and about creativity (Eisner, 2008). The strength of using the arts may be found more in the reflection and deepened sense making they provoke. Most would agree, learning is transformative if it involves critical reflection - an analysis of taken-for-granted assumptions and expectations (Brookfield, 2000; Taylor & Cranton, 2012). Arts-based community programs encourage critical reflection and expression in a supportive setting.

The Canadian Medical Association (2013) reports two thirds of those suffering from mental health problems are silent, fearing judgment and rejection. This persistent culture of suffering in silence can lead to lower self-esteem and a variety of adverse emotions, including shame, anxiety and fear. Polanyi (1966/2009) states, "we know more than we can tell" in reference to the appreciation of tacit or unspoken knowing (p. x). Embodied activities such as the arts can tap into knowing that has often been silenced (Horrsfall and Titchen, 2009). Expressing embodied stories through the arts (for example, visual arts, narrative, storytelling, and so on) can be a medium for self-discovery, acceptance of self and others, and a way to communicate representational knowing that comes from within (Lawrence, 2012). *Embodied knowing* is a form of experiential learning as our life experience is inevitably mediated through our bodies (Shilling, 1993, p. 22) In essence, through participation in the arts, the artists may learn more about themselves and the social context which they have experienced (Cajete, 1994).

The arts have the power to enable disclosure. The lack of public conversation about mental illness is a barrier to revising meaning schemes (Brookfield, 2011). Many arts-based community programs take on a critical stance related to breaking silence, naming injustices, and imagining alternative worlds (Butterwick & Dawson, 2006). Critical reflection is important when challenging paradigmatic assumptions associated with mental illness (Brookfield, 2011). Arts based programs invite participants to critically reflect on and become makers of culture rather than just passively adapting to what exist. Transformative learning involves a fundamental shift in our habits of mind that shape our self-image and cultural expectations. The strengthening of identity and confidence of the artists who participate in community programs is contingent on their readiness and the supportive space provided—a place that provides a form of validation of their art though presence and dialogue. Arts-based community programs can be a spark for transformation.

Concluding Thoughts

The arts are important to adult education, cultural democracy, and social change (Clover, 2006). The goal of cultural democracy is to provide cultural opportunities through a more participatory venue, which encourages expressions and practices outside of the mainstream (Goldbard, 2006). Arts-based community programs provide a space for participants to express their identity and broaden their understanding of self and society. While, critical deep thinking is the cornerstone of transformative learning, aesthetic forms of knowledge production and meaning making can emerge through engagement in grassroots experiences that allows for art making and disclosure, honouring emotions, and imagining alternate realities.

Recovery is not defined as the absence of illness; rather, recovery involves the restoration of hope, identity, self-determination, and self-worth (Coleman, 1999). In making art, the artists is not a passive person with a disability, but rather part of active art making; the individual is finding a way to communicate with a new sense of cultural identity (Clover, 2006). This action can build self-confidence.

Research supports the notion of building a more resilient life with social and cultural connections through relationships and participation in the arts and activities (Olson et al., 2015). The benefits of resilience could extend to participants involved as makers of the art and additionally to those who witness the art and vicariously and respectfully share the experience - among them family, friends, health care providers and community members. (Horton-Deutsch et al., 2011).

The arts can evoke a harmony of responses - a deepened personal dialogue and social conversation cultivating expression, imagination, and transforming thought. Engagement with creative practices in the arts is a way of knowing and a kind of action-arousing our senses and our intellect, providing opportunities for individuals to contribute to society, like anyone else, and, for some individuals, sparking hope to dream about a different future.

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Promoting psychosocial recovery through creative arts: unfolding of a pilot hospital project
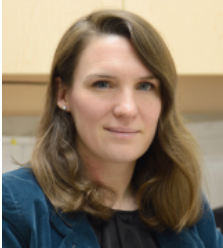
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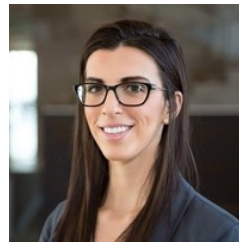
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ABSTRACT

The Recovery Through Creative Arts (RTCA) program at Parkwood Institute, Mental Health Care (PIMHC) is a recovery-oriented program. It seeks to provide therapeutic opportunities for healing and successful community reintegration post-discharge through relationships created within the program. This article describes the process of implementing the RTCA program in inpatient programs at Parkwood. Strategic implementation of the program was undertaken by a multi-organization project team using broad local stakeholder consultations.

The RTCA program currently consists of four different creative arts drop-in workshops per week: music, drama, visual arts and dance. The workshops are facilitated by local community artists from the London Artist in Residence (LAIR) program with the London Arts Council (LAC). These two bodies designed a step by step implementation strategy embedded to ensure activity alignment with patient and staff schedules and resources. At the outset, flexibility in monthly schedules was achieved as a broader reach to the inpatient population who were not able to leave the unit. The tutor Artists adapted tasks to suit the individual needs of participants attending each workshop. This proved to create satisfaction from participants who at times could feel challenged or disconnected from the planned activity. Allocation of facilitators for each workshop session was modified based on need as the workshops rolled out. Our ongoing evaluation of the program indicates a need to predictably align volunteer and staff resources to support patients' attendance and participation in the scheduled workshops. Support staff expressed deep gratitude and joy from participation in the RTCA program and from witnessing the positive impact it has on others.

Conclusions: Human resources to support the workshops need to be flexible to adapt to both the activity being provided, and the participants in attendance. Additionally, workshop scheduling needs to accommodate care planning and competing treatment activities. Hospital staff and LAIR artists have collaborated to assess these considerations on a weekly basis. Additionally, data from this pilot phase will be used to inform plans for the development of a sustainable model and demonstration of effectiveness and impact from the perspective of multiple stakeholders, including patients and their family.

Limitations: Potential limitations can be attributed to biases due to self-reported data in relation to staff and/or facilitator (artist) observations and participant self-perspectives.

Introduction

Since the early 19th century, the therapeutic use of the creative arts has been recognized as a valuable means of supporting people with psychosocial disabilities (Gladding, 2005; Mee & Sumsion, 2001; Reynolds, 2000; Spandler et al., 2007; Tubbs & Drake, 2007). Research has shown positive change and benefits for people experiencing mental illness who engage in artistic activity. For instance, significant improvements in self-esteem, self-worth, self-efficacy, empowerment, confidence and achievement are consistently reported (Cohen, 2006; Goldie, 2006; Griffiths, 2008; Heenan, 2006; Stickley, Hui, & Morgan, 2007; Timmons & MacDonald, 2008). A limited number of randomized trials have evidenced that involvement in creative therapies can contribute to improved mental health and social functioning for people experiencing schizophrenia (Crawford & Patterson, 2007). Studies by Rebeiro (Rebeiro & Polgar, 1999; Rebeiro et al., 2000) and Griffiths (2008) support the outcomes of

gaining skills, a sense of achievement, accomplishment, enhanced self-confidence and feelings of self-satisfaction. Rebeiro (2000) and Griffiths (2008) also identified clients' feelings of hope and a sense of purpose as outcomes from engagement in creative activity. Griffiths (2008) reported key ingredients for achieving such outcomes: First, letting clients exercise their agency to choose whether or not to actively engage in creative activities. Moreover, providing clients with options for creative activities and allowing them to choose their preferred activity. Second, Griffiths (2008) identified an environment that is accepting, predictable, and one that abdicates clients of responsibility or expectations about their artistic skill as integral to successful artistic therapeutic activity.

The positive experience of creative activities alongside others in such an environment provides. Non-threatening opportunities for social interaction (Griffiths, 2008). Indeed, Rebeiro et al. (2001) confirmed that an environment that is both physically and emotionally safe is important in the process of healing and recovery.

Rebeiro and Cook (1999) further demonstrated the importance of acceptance and affirmation of individuals partaking in creative activities. Indeed, self-expression and self-discovery through the arts - music, performance, visual, and writing - may reduce the burden associated with various types of health conditions and life circumstances by increasing participants' sense of hope (Kim, Kim, Choe, & Kim, 2018; Moss, Donnellan, & O'Neill, 2012).

Art making in community settings can enhance overall general health through strengthening self-esteem and self-worth, contribute to a feeling of being valued, facilitate development of interpersonal relationships, and widen social networks (Camic, 2008; Staricoff, 2004; White, 2009). For instance, participants of a community-based art therapy program in Northern Ireland reported a sense of independence and the ability to participate in other social activities through their participation in the art therapy (Heenan, 2006). Art therapists and artists have a unique and powerful means for engaging and healing communities, reducing stigma, and generating social change (Ottemiller & Awais, 2016).

Given the significance of the creative arts in the delivery of recovery-oriented psychiatric rehabilitation, the Recovery Through Creative Arts (RTCA) program was developed at Parkwood Institute, Mental Health Care (PIMHC), for adolescents and adults with enduring mental illness and significant psychosocial disability who are inpatients of this tertiary care facility. This creative arts program was created as a means to provide opportunities for patient recovery and meaningful patient-artist relationships which may assist in community reintegration following discharge.

Building upon established and solid relationships with community-based mental healthcare organizations (as further described below), it is intended that the RTCA program present multiple opportunities for patients to engage in a variety of creative arts programs to facilitate their journey of recovery, hope and healing. The staged implementation of the program allows for the individualized alignment of activities with unique participants' needs and interests thus allowing the clinical team to create outpatient transitional goals.

The objectives of this paper are as follows: (i) describe the development and implementation of the Recovery Through Creative Arts program, (ii) showcase the initial, informal impacts of the program on patients as well as its observed strengths and shortcomings, (iii) provide an overview of a formal evaluation of the program, and (iv) discuss the next phases of the implementation and evaluation.

Implementation of the Recovery Through Creative Arts Program

The RTCA program began in November 2017 and initially[1] offered four different creative arts activities: music, drama, visual art, and creative writing/spoken word (see **Table 1**) in drop-in workshop format to inpatients at the discretion of the clinical team. Each workshop is facilitated by a professional community artist and/or a peer facilitator with lived experience of mental illness. Workshops are offered over a two-hour period, they can accommodate between 10 and 30 patient participants, and are offered two evenings and two afternoons during the week. The potential to offer programming on weekends is to be considered as there is currently a shortage of structured activity options for patients during those times. To maximize accessibility and patient engagement, workshops are held in common areas of the parent institution Parkwood Institute Mental Health Care such as the main floor lobby/cafeteria area (known as [Downtown] and auditorium. Some workshops are held on the inpatient units to provide access to those who are unable to leave the unit.

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[1] Creative writing/spoken word ended in April 2018 due to artist unavailability; dance was trialed for 12 weeks in June 2018, and has been running consistently as of January 2019.

Table 1. *Description of RTCA Activities*

Activity	Description	Schedule and Location
Music	Sessions to perform, sing, interact or observe musical activities. Facilitated by a professional musician and Peer Facilitator from LAIR program Belong To Song.	Tuesday evenings 5:45pm – 7:45pm in the auditorium, located on the main floor on Parkwood MHC Inpatients[2] with off-unit privileges are welcome
Visual Arts	Media include drawing and sketching, acrylic paints on canvas, water colour, print making, and/or clay, linking content to the personal stories, interests and/or issues faced by the participants. Facilitated by a LAIR artist-educator	Wednesday evenings 5:45pm – 7:45pm in the main lobby ("Downtown") of Parkwood MHC Inpatients with off-unit privileges are welcome
Creative Writing/Spoken Word	Various forms of writing, poetry, script writing, personal narratives/monologues, and short story, linking content to the experiences, interests and/or issues faced by the participants. Facilitated by a LAIR artist	Wednesday afternoons 1:15-3:15pm in a meeting room located between the third floor inpatient units. Inpatients with off-unit privileges are welcome
Drama	Improvisation and trust-building drama games, exploring script writing, Reader's Theatre and/or the creation and presentation of short pop-up performances. Facilitated by a LAIR artist	Thursday afternoons 1:15-3:15pm on rotating inpatient units: The two units on floor three each receive individual drama program sessions for 40-50 minutes. The other two units on floor four receive the program, each for 40-50 minutes, the next week. From November 2017-2018, drama occurred on the adolescent inpatient unit once per month. As of January 2019, drama occurs on the Dual Diagnosis unit once per month.

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[2] Inpatients from the Geriatrics and Dual Diagnosis units were welcome with staff discretion for the music, visual arts, and creative writing. Drama and Dance are modified and offered on these particular units to fit unique patient needs.

Dance	Different genres of dance (e.g. hip hop, ballroom) demonstrated and taught to patients in an interactive session. The history of dance is explained as certain styles of dance are introduced. Facilitated by a LAIR artist.	Wednesday afternoons 1:00pm-3:00pm in the gym, located on the main floor of Parkwood MHC. Inpatients with off-unit privileges are welcome As of January 2019, the first 60-70 minutes of the dance program are in the gym. Subsequent 30-minute modified sessions occur on the Geriatrics unit one week, and the Dual Diagnosis unit the next week.

Development of the RTCA Program

The implementation of the RTCA program has involved the collaboration of many partners including clinical staff [i.e., Recreation Therapists (RTs), Occupational Therapists (OTs), Nurses (RNs)], hospital management, the Parkwood Patient Council, the Parkwood Family Advisory Council and Volunteer Services; union leaders, the London Arts Council, St. Joseph's Health Care Foundation and Lawson Health Research Institute. Currently, RTs attend each RTCA workshop to help patients come and go from the activities when necessary and to support patients' participation. Staff also partner with the workshop artist facilitator to manage the milieu, and they participate in the activities to facilitate patient involvement. Appendix A provides further information on the partnering organizations with the RTCA program.

During the planning and initiation phase in late summer and early fall of 2017, the RT team met weekly with the Project Sponsor to review their role in supporting the workshops and explored voluntary schedule changes to facilitate their participation. The RT team also discussed successes and challenges in the workshops, provided suggestions, and collaborated with the program artists to support their tutoring.

As a planning priority the workshops were scheduled so as to avoid creating additional workload pressure for the RTs and to support them in sharing the responsibilities for centralized programs in a way that allowed them to take an active role. As funding restrictions prevented the introduction of additional clinical staff, the RT team supported the creative arts program within existing resources. This introduced the opportunity to partner more closely with all front-line staff, union leaders, Patient Council volunteers and Volunteer Services to maximize clinical and informal supports for the programming. Opportunities to integrate the use of space and supportive resources was identified as a way to create greater visibility for the RTCA program and to combine formal and informal human resource structures to support and supervise the RTCA activities.

Additional clinical staff members volunteered to change their schedules to work later, in order to further support evening RTCA workshops. All hospital staff were also encouraged to attend any component of these workshops with patients, as the workshops offer an opportunity to learn about community resources and witness the skills the patients exhibit as well as the potential impacts of the creative arts for patient recovery. Inpatients were encouraged to participate in the workshops and may continue to do so once they transition to being outpatient. Small samples of outpatients who are not currently connected to community programs do attend the evening RTCA workshops.

The workshops were advertised and introduced through posters, centralized calendars, and discussions between clinical team members and patients during care planning. Participant engagement is being observed and documented. Focus groups and key informant surveys, are

also underway, as further described in the following section.

Evaluating the RTCA Program

Introducing this program as a two-year pilot creates the opportunity for program evaluation and there is the potential for contribution to research in recovery-oriented interventions and treatments. Researchers from the Lawson Health Research Institute have designed evaluation tools to assess the RTCA program's reach, implementation, and acceptability during the first year of the program from the perspectives of patients, hospital staff, management, Patient and Family Council members, and artist facilitators. The ***objectives of this evaluation are to:***

1. Understand the implementation of the RTCA program, including program reach, resources used, critical elements for sustainability
2. Understand the facilitators and barriers to the implementation of the RTCA program; and,

3. Investigate the potential effects of the RTCA program, including acceptability, on patients, hospital staff, management, and artist facilitators. These objectives will guide future phases of this research, including improvements/ adjustments to the RTCA program, and sustainability beyond the second year of the RTCA program.

Methods

The research team has approval from the Western University Research Ethics Board to conduct the program evaluation. The following sections describe the proposed evaluation process and methodology.

Participants. A range of stakeholders will participate in the program evaluation:

(a) All capable inpatients participating in the RTCA program (n=12);
(b) The RT team involved in the RTCA program (n=8);
(c) Hospital Inpatient Staff [i.e. RNs, allied health, unregulated care providers (child and youth workers CYWs and developmental service workers DSWs), RSWs, OTs and Psychiatrists] familiar with but not directly involved in the program (n=1);
(d) RTCA program leaders (n=2);
(e) Artist facilitators and peer supports (i.e. facilitators with lived experience of mental illness; n=4 artists; n=5 peer supports);
(f) Parkwood Institute MHC management (n=1);
(g) Members of the Parkwood Family Advisory Council[3] (n=8); and,
(h) Members of the Parkwood Patient Council[4] (n=2)

Procedure

All participants will be invited to take part in evaluating the implementation, acceptability and sustainability of the RTCA program, either by in-person information sessions, and/or email contact. Informed consent will be obtained for all study participants. Subsequently, participants will be contacted to partake in a variety of data collection procedures (see below).

Data will be collected through the use of qualitative and quantitative methods, including focus groups, group consultations, individual interviews, and questionnaires (delivered in person or via email), at two-time points: Time 1 will occur approximately six months into the RTCA program and Time 2 will occur approximately one year into the RTCA program. Some study participants will participate at both data collection times and some will participate in more than one method of data collection (e.g. questionnaire and focus group).

Time 1 data collection seeks to provide preliminary answers to all three aforementioned research objectives and will document the process of implementation, including:

(a) the critical elements for sustainability (i.e. hospital resources needed to sustain the RCTA program);
(b) exploratory (hypothesis generating) effects/impacts of the RTCA program to inform the conduct of a future trial of effectiveness.

Time 2 data collection will build on data collected at Time 1 and will seek to further develop the three research objectives and further understand:

(a) facilitators and barriers to the implementation of the RTCA program, and

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[3] The Family Advisory Council consists of family members of patients who have received care at Parkwood Institute. The Council strives to help staff deliver care that is sensitive and responsive to client and family needs (SJHC, 2019).

[4] The Patient Council Patient participants must be 16 years of age or older and their eligibility to participate will be dependent upon the assessment a researcher at the time of informed consent.

(b) potential effects of the program from a variety of perspectives (i.e. artist facilitators, patients, hospital staff, management and leadership, and Patient/Family Council members).

Table 2. *Program evaluation procedure*

Phase 1 of Evaluation	Participants to be included	Data collection method	Data analysis
0-6 months	1. Inpatients participating in the RTCA program (n=12) 2. TR staff involved in the RTCA program (n=8) 3. Artist facilitators (n=4) 4. Peer facilitators involved with Belong to Song (n=5) 5. RTCA program leaders (n=2)	Separate Group or individual interviews were conducted by a researcher for each participant group. Interviews are audio recorded. Patient demographic data, patient satisfaction, and patient attendance data for phase 1 are also collected.	All interviews are transcribed and subjected to a thematic analysis to answer the research questions. Demographic data, satisfaction levels, and attendance data are analyzed using appropriate quantitative methods.
Phase 2 of Evaluation	**Participants Included**	**Data Collection method**	**Data Analysis**
7-12 month	All participant groups included in phase 1, plus the following: 1. Patient Council members 2. Family Council members 3. Other Hospital unit staff (e.g. RNs, OTs) 4. Hospital Management staff (e.g. Program coordinators)	Separate Group or individual interviews are conducted by a researcher for each participant group. For hospital unit staff and hospital management, the interview questions are sent (and responded to) over email. In person interviews are audio recorded. Patient attendance data for phase 2 is collected.	All interviews are transcribed and all data is subjected to a thematic analysis to answer the research questions.

Measures

1) Demographic data. Basic socio-demographic data including ethnicity, education level, and marital status will be collected via a self-report questionnaire to be completed at the beginning of the first focus group (Time 1). Demographic information will only be collected for patient participants.

2) Program reach. Program reach refers to the number and representativeness of patients who participate in the RTCA program. Reach will be evaluated by

collecting attendance on an ongoing weekly basis at each RTCA program workshop for 12 months. Core Clinical Support Staff will document patients' first and last names, and their hospital unit.

The Artist Facilitators will also document their observations and reflections on patient engagement and participation. The data from these reflection sheets will be

analyzed by the researchers. See Appendix B for the reflection sheet.

3) Client satisfaction. The Client Satisfaction Questionnaire-8 (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) is a 10-item questionnaire that asks about patient satisfaction with a program/practice. The CSQ-8 has been used with mental health populations in the past. It will be administered to patient participants by the researchers before the Time 1 focus group. A health care professional will be available to assist with completion of the CSQ-8, if needed.

4) Themes from Focus Groups/interviews.

Participants will be asked to describe and discuss the following themes of the RTCA program from the focus groups/interviews at Time 1 and Time 2: 1) overall reaction to the program, 2) positive elements of the program, 3) aspects of the program that could be improved, 4) possible enhancements, 5) perceived facilitators and barriers to successful implementation of the program, and 6) any effects of the RTCA program on the different participant groups. For instance, the TRs are asked to comment on how the RTCA impacts their patients' recovery (if at all), as well as how the RTCA may be impacting their own views of recovery and mental illness.

Hospital unit staff and hospital management staff participants also have the option to answer the interview questions via email for their convenience. See Appendix C for the (1) patient participant interview/focus group guides, and (2) questions for hospital staff and management distributed over email.

Synthesis of Results

To ensure a comprehensive examination and understanding of the RTCA program from multiple stakeholders, multiple methods of data collection have been utilized (see method triangulation; Patton, 1999). The focus groups, interviews, and group consultations will be transcribed and analyzed using thematic analysis: the data will be categorized into different themes that are dependent on the content in the transcripts (Braun & Clarke, 2006). Further, a descriptive analysis will be conducted with the quantitative self-report questionnaire data (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen,

Discussion

1979) to ascertain the demographics of the sample and how satisfied patients are with the RTCA program. The results are to be analyzed in accordance with the first two dimensions of the RE-AIM Framework. The RE-AIM Framework provides a model to systematically consider the strengths and weaknesses of health-related interventions/programs (e.g., Gaglio & Glasglow, 2012; Glasglow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004; Glasglow, Vogt, & Boles, 1999). According to the RE-AIM framework, five essential elements of a program should be considered and evaluated (Glasglow et al., 1999): Reach, Effectiveness, Adoption, Implementation, and Maintenance.

Reach refers to the number of individuals willing to partake in the RTCA program. *Efficacy* involves the impact of the RTCA program on important outcomes (e.g., patient recovery). The next three components, although not being evaluated in this research, are worth describing briefly. *Adoption* refers to the absolute number of settings and intervention agents (people delivering the program) who are willing to initiate a program. *Implementation* is the fidelity of the intervention agents in terms of the various elements of an intervention's protocol, including the consistency of delivery as well as the intended time and cost of the intervention. Implementation can also refer to the client's use of the intervention strategies (Glasglow et al., 1999). *Maintenance* is the extent to which a program/intervention becomes integrated as part of the routine organizational practices (Glasglow et al., 1999). The developers of the RE-AIM Framework acknowledge that the specific way the framework is applied can vary, and it is common to selectively measure one or two RE-AIM dimensions (Kessler et al., 2012).

Implications

Participants' input will be used to help increase the researchers' understanding of the acceptability and potential therapeutic benefits of the RTCA program in the recovery process and recovery planning for people with mental illnesses in hospital. The information collected will help inform the connection between the creative arts and recovery from mental illness, along with the importance of community integration and supportive networks in promoting recovery during and after hospital discharge. The information obtained from this research is also necessary to guide future research into evidence-based art as mental health recovery.

Recovery focuses on people regaining their quality of life while striving to achieve their full potential. Unlike a cure, recovery goes beyond the reduction of symptoms and considers an individual's wellness from a holistic perspective that includes relationships, community involvement, general wellbeing and sense of empowerment (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). The RTCA program can reduce barriers to recovery such as social isolation and provide patients with hope by allowing them to benefit from participating in the creative arts in a safe and supportive setting. As stated by Jackson (2015), "…addressing the issues of self-concept, self-efficacy, and quality of life is integral to successful recovery from mental illness."

Giving patients the opportunity to explore and experience the arts while in hospital not only assists with recovery but inspires individuals to begin developing their strengths as soon as possible. Art-based practices greatly benefit psychological and social recovery, particularly in the areas of self-discovery, self-expression, relationships and social identity (Van Lith, Schofield, & Fenner, 2013). Employing peer supports and professional artist facilitators from existing community programs will not only provide a therapeutic opportunity for healing and recovery; patients may continue to engage in these creative activities, establish social connections, daily structure, and be able to access other natural supports, thereby creating a more meaningful life and continued recovery. For those facing mental health challenges, artistic expression can be integral to well-being and the beginning of recovery by providing support, encouragement and a sense of camaraderie. The RTCA program builds upon existing relationships and successes of our community partners and aspires to create a beneficial program that will demonstrate the need for sustainable funding and permanent programming.

The introduction of the RCTA program as a pilot project is intended to provide therapeutic opportunities for healing and recovery and to create a relationship-based safety net for patients' successful transition to the community post-discharge from a tertiary care inpatient unit. This article has described the process of implementing the RTCA program at the Parkwood Institute of Mental Health Care inpatient programs. The purpose of embedding implementation research and evaluation into the RTCA program is to allow for ongoing adaptability to the needs of the patients and to identify the acceptability, benefits and feasibility of the RTCA program to inform future implementation, scaling and study of effectiveness.

In accordance with the RE-AIM Framework, future research should seek to evaluate the adoption, implementation, and potentially, the maintenance of the RTCA program to further inform future design, planning, and implementation of the RTCA program.

Funding

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Appendix A

Recovery Through Creative Arts program Partners

Belong to Song

In February 2016, Belong to Song (BTS), operating since 2010, became a program of the London Arts Council within the London Artist in Residence program. BTS is a community-based music program with core values of inclusion, acceptance and belonging. This program is co-led by a peer musician and a professional musician. Some participants come to listen, others to play an instrument or sing, and the facilitators ensure that everyone who wants to perform has an opportunity. Through the RTCA program, patients at PIMHC can experience BTS while in hospital, and then reconnect to the program in a community setting upon discharge. BTS is supported by the Mental Health Promotions Committee at PIMHC.

London Artist In Residence

The London Arts Council's London Artist In Residence (LAIR) program involves professional artists working with students and teachers in Thames Valley District School Board and London District Catholic School Board schools, as well as with educational programs at local and regional professional arts venues and museums. LAIR's scope is expanding to include artists working in mental health care settings such as PIMHC to enhance the quality and quantity of in-hospital arts programs.

City Art Centre

PIMHC patients and staff have a well-established history with the City Art Centre (CAC). The CAC offers a welcoming, safe environment for self- identified, self-responsible and self-directed adults to express themselves through a variety of artistic mediums. Founded in 1992, CAC provides a co-op art studio, gallery and meeting place where members can use the full range of art supplies, participate in workshops and join in quality of life discussion groups.

Appendix B

Artist Tracking Sheet

Recovery Through Creative Arts program LAIR Artist Tracking Sheet

Artist: Arts Genre:

Study ID number:_____

session time & date	participant comments	artist observations & reflections on participant engagement & skill development

Appendix C

Participant Focus Group Guide – Patients

TIME 1 Focus Group Questions:

You have been involved with the Recovery Through Creative Arts program, and we are going to ask you some questions about your thoughts and experiences about this involvement. Your comments/ thoughts will be helpful to us in understanding what about the program is going well, and what about the program could be improved so far.

1. Think back to when you first became involved with the Creative Arts Program. When did you first become involved with the program, and what were your first impressions of the program? Feel free to share as many description words as possible.

2. The Creative Arts Program offers many different types of art, including drama, music, visual art, and spoken word/writing. So far, which arts groups have you participated in?
   a. Which arts group(s) do you like the best, and why?
   b. Which arts group(s) do you like the least, and why?

3. What makes you keep coming back and participating in the arts group(s)?
   a. If you have stopped attending the arts group(s), what made you stop participating?

4. Now that you have been involved with the program, how would you describe the Recovery Through Creative Arts program to somebody who has never been involved before?

5. So far, what do you like most about being involved in the Recovery Through Creative Arts program?

6. What are the artist facilitators doing well during the Recovery Through Creative Arts program?

7. What could the artist facilitators improve upon for the Recovery Through Creative Arts program?

8. If you had the option of recommending the Recovery Through Creative Arts program to other people, would you choose to do so?
   a. If YES, why would you make the recommendation?
   b. If NO, why wouldn't you make the recommendation?

   c. Do you think you will continue to participate in the Recovery Through Creative Arts program at Parkwood? Why or why not?

9. Is there anything else you would like us to know?

TIME 2 Focus Group Questions:

It has been approximately 6 months since our last meeting together. We are going to ask you some questions about your thoughts and experiences about your participation in the Recovery Through Creative Arts program at Parkwood, and your involvement with the arts in the community. Your comments/thoughts will be helpful to us in understanding what impact this program had in your lives, what about the program works and what about the program could be improved upon.

1. Think back to when you first became involved with this Recovery Through Creative Arts program. What was your initial opinion of the program?
   a. Has your opinion changed? If so, how?

2. For you, what was the best part of the Recovery Through Creative Arts program?
   a. What about this made it the best part?

3. For you, what part of the Recovery Through Creative Arts program needs the most improvement?
   a. What would you include/change/remove to improve the program?

4. How has participating in the Recovery Through Creative Arts program helped you with your recovery?
   a. What are some skills / ways of thinking you got from the program that you have carried forward, or want to carry forward?
   b. What are your goals / wishes for your recovery and how has the program influenced your goals?
   c. What does quality and meaning in life mean for you?

5. How does the Recovery Through Creative Arts program compare to other activities you participate in today/have participated in in the past?

6. If you could advise decision-makers about Recovery Through Creative Arts programs like this one, what would you want them to know?

7. What did the artist facilitators do well during the Recovery Through Creative Arts program?

8. What could the artist facilitators improve upon for future Recovery Through Creative Arts programs

9. If you had the option of recommending the Recovery Through Creative Arts program to other people, would you choose to do so?
   a. If YES, why would you make the recommendation?
   b. If NO, why wouldn't you make the recommendation?

10. Do you currently participate in similar creative arts activities in the community / Do you think you would want to participate in similar creative arts activities once you re-enter the community?
    a. Why or why not?
    b. What would help you be able to participate in similar creative arts activities in the community?
    c. What is currently making (what do you think will make) it difficult for you to participate in creative arts activities in the community?

11. Is there anything else you would like us to know?

Emailed Interview Questions for Hospital Unit Staff

INTRODUCTION AND INSTRUCTIONS for TIME 2

Hello, my name is Elizabeth Price, and I am the research assistant working on the evaluation of the Recovery Through Creative Arts program. Thank you for agreeing to participate. Just to remind you, I am looking at opinions about what your involvement in/awareness of the Recovery Through Creative Arts program means to you. Please read the following information.

- The information which I will collect today will be attributable *(connected or associated)* to you <u>as a member of hospital unit staff at Parkwood MHC</u>.
- I will not identify quotes or ideas *any one person* of this group. Because of the nature of small communities or groups, it is possible that people could link you to quotes in the report. This is why I need to tell you about confidentiality.
- **I *am* assuming that when you respond to these questions, you will use your secure, hospital email account, and *not use* an external email account.**
- Due to the nature of email communication, I cannot guarantee that your responses to the questions will be 100% confidential.
- So please make only those comments that you would be comfortable making in a public setting; and to hold back making comments that you would not say publicly.
- Names will be removed from all responses. Participants will have coded numbers attached to their names which only I will know.
- Only I and the other researchers will have access to the emailed responses.

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1. What were your initial impressions & opinions of the Recovery Through Creative Arts program?

2. Is other staff on your units aware of/involved with the program?

   a. If yes, what are the roles of the other unit staff in relation to this program?

   b. If no, why do you think staff is not aware/ involved?

3. How do you select patients to participate in the Recovery Through Creative Arts program? Can you describe who attended the groups *(prompt - for example, were they of a particular age group, gender, or level of recovery?)*

4. From your perspective, what has helped patients to participate in this program? (*Prompt – Sessions on the unit versus in the downtown area, length of sessions and frequency – what seems to work best?*

5. From your perspective, what has hindered patient participation?

6. What (if any) program restructuring/service change had to happen on your unit in order for the Recovery Through Creative Arts program to be implemented successfully?

   a. Can you describe changes you made to implement the program into your unit's schedule?
   b. What factors have supported the uptake of the program?

   c. What factors, if any, have hindered the uptake of this program?

7. Since the Recovery Through Creative Arts started, do you think it has impacted patient recovery?

    c. Why or why not?

    d. Can you comment on the connectedness and sense of community amongst patients?

8. Would you recommend the Recovery Through Creative Arts program as an activity for patients in similar mental health care settings?

9. Is there anything else you would like us to know

Emailed Interview Questions for Hospital Management Staff

INTRODUCTION AND INSTRUCTIONS

Hello, my name is Elizabeth Price, and I am the research assistant working on the evaluation of the Recovery Through Creative Arts program. Thank you for agreeing to participate. Just to remind you, I am looking for your opinions on the Recovery Though Creative Arts program and Parkwood Institute Mental Health Care. Please read the following information:

- The information which I will collect today will be attributable *(connected or associated)* to you <u>as a member of hospital management at Parkwood MHC.</u> .
- I will not identify quotes or ideas *any one person* of this group. Because of the nature of small communities or groups, it is possible that people could link you to quotes in the report. This is why I need to tell you about confidentiality.
- **I *am* assuming that when you respond to these questions, you will use your secure, hospital email account, and *not use* an external email account.**
- Due to the nature of email communication, I cannot guarantee that your responses to the questions will be 100% confidential.
- So please make only those comments that you would be comfortable making in a public setting; and to hold back making comments that you would not say publicly.
- Names will be removed from all responses. Participants will have coded numbers attached to their name which only I will know.
- Only I and the other researchers will have access to the emailed responses.

1. When / How did you first hear about the Recovery Through Creative Arts program at Parkwood MHC and what were your initial thoughts about the program?

2. The vision and mission of St. Joseph's Healthcare London involves advocating for those who are vulnerable and without a voice, making a lasting difference in the quest to live fully, and improving health and minimizing the effects of injury, disease and disability. In your opinion, does the Recovery Though Creative Arts program align with the hospital's mission and vision? Please explain.

3. From your perspective, has the Recovery Though Creative Arts program contributed to and/or impacted service delivery at Parkwood MHC? Why or Why not?

4. From your perspective, has the Recovery Though Creative Arts program impacted staff and/or other hospital level processes/practices? Please explain.

5. What are some strengths of the Recovery Though Creative Arts program
   a. From an operational perspective?

   b. From a clinical perspective?

6. What are some weaknesses (if any) of the Recovery Though Creative arts program from an operational and/or clinical perspective?

7. Please comment on the sustainability of the Recovery Through Creative Arts program. What is needed to sustain this program for future patients at Parkwood MHC?

8. Please comment on the scalability of the Recovery Though Creative Arts program. In your opinion, could this program be implemented in similar health care settings? Please explain.

9. Do you have any other comments/concerns that you would like to add?

Writing to Heal

Harry Kuhn
Email: harrykuhn@ymail.com

I have schizophrenia. I have been in remission for years and I've been writing for years. Most of my writing is creative non-fiction, but some has also been expressive writing where I have written about difficult past experiences and my feelings about them. My published works have been based on positive experiences, however, as focusing on them has helped me gain a more balanced perspective on my life as a whole: in essence, that my life at home was an unhappy one, but it was not all bad. I did not start out with the idea of achieving balance, I started out wanting to learn how to write. The memories of better times simply came to mind on their own. I discovered that there were times that I liked to remember. I have also had two short pieces of fiction published and have some short stories that I have yet to submit anywhere.

According to Forgeard et al. (2014), "Although expressive writing does not resemble typical creative writing activities, because the main focus of the writing is on real past events, participants are nonetheless asked to write about these events in a way that allows for the expression of original ideas". In my own experience of expressive writing, I focused on childhood events where the adults in charge of me were a source of traumatic experiences. Whether it was my dad being so drunk that my two sisters close to me in age and I had to be slipped out of our house at night because he had become a threat to us, or the unpredictable temper of the woman who took charge of me when I was sent to live with my oldest brother, the experiences were never far from my mind and simply to talk about them did not lessen their impact on me. I internalized all the negative remarks I was subjected to growing up that undermined my confidence and self-esteem. I took being called a jackass, an idiot, or simply being criticized for ideas that were not what or how my sister-in-law would do a thing, to heart. I found her hostile moods so unpredictable that I was never sure for how long I would be spared more verbal abuse. I also had a failed marriage that caused a breakdown for me. The last few years of marriage were a litany of insults and accusations. I know now that these experiences were complicated by my mental illness, by my already present doubts about myself.

Expressive writing and the Cathartic Experience

Early in my journey of learning to write, I wrote short pieces about specific events from my past and my conflicted feelings. I took these stories to a writing group I belonged to and read them to the group. Both parts of the process were necessary for me to experience benefits: objectifying the experiences in writing them, making the emotions manageable, and then sharing with a group of people who expressed understanding and could even identify with what I was saying. In studies of expressive writing the written material was held anonymous and no feedback was given (Sexton & Pennebaker, 2009), but in my case the cathartic experience of being understood was a necessary element. With feedback, I felt a release of anxiety about the experiences and at the same time began to understand that much of what troubled me was what had been said to me, not who or how I really was. This confirms the view of view of Forgeard et al, 2014): "Thus, it is possible that writing done in this paradigm falls on a continuum of creativity, depending on the degree to which writers express novel and useful insights about their experiences."

The subject of a piece would come from ruminations about the past that were causing me depression or anxiety for a period of time. Occasionally a comment from someone would trigger an unpleasant memory. I would finally take pen and paper and begin to write as though I were telling some nameless person about the experience and the feelings associated with it. I did not do any editing with these pieces, but with a certain amount of anxiety I would either send them to a friend I trusted or take them to the writing group. I believe I may have hit upon the idea of doing this from my experience with cognitive behavioural therapy which involves writing about your thoughts and emotions,.

Creative Writing and the Experience of Flow

I moved on from expressive writing to creative writing, using story telling techniques that apply also to fiction. I developed my own system of dwelling on an idea for some time until I had a mental impression of how I wanted to tell the story. The stories were true to life, memoirs, but told more in the style of short stories. When I would finally sit down to start writing, I was completely focused on what I was writing and sometimes the whole night would pass and I was unaware of the passage of time until I stopped. An example would be a story I had published called "Me and Clarence" (Kuhn, 2015). The events of the story about a childhood toy that used to belong to my sister but was given to me and our disagreements about which of us actually owned it and that even in recent years we still debated ownership, are true. When I told a friend about it she told me that it sounded like a story outline. Immediately I began to be preoccupied with turning it into a written story. During the writing of it I was completely focused, including the editing stage. It is a short story but including the initial editing I was working on it all night and only stopped when I felt I had done as much with it as I could. It was approximately 6 am by that time. I then left it alone for a while and later had it critiqued by a retired English teacher. It was approximately a year from writing it to its appearing in print.

This reminds me of the concept of flow, i.e. the experience of seeing the writing exudes out of oneself while being totally absorbed with a concept as described by Forgeard et al (2014):

> Csikszentmihalyi's (1990) concept of flow provides one mechanism explaining how creativity may increase well-being. Csikszentmihalyi developed the construct of flow in the 1960s as a result of observing artists paint (Csikszentmihalyi, 2000). Flow is a psychological state defined by the presence of both high skills and high challenges giving individuals a sense of control over the activity at hand. It is characterized by intense focus and concentration, a merging of action and awareness, the feeling that the passage of time may be distorted in some way, and intrinsic reward. The experience of flow helps explain how creative involvement may benefit various facets of psychological well-being including a sense of personal competence, accomplishment, positive emotion, and meaning in life (Csikszentmihalyi, 1996; Forgeard and Eichner, in press). (p.327)

I experience flow in both the first draft writing of a piece and in the editing stage. I have no awareness of the passage of time or how long I have been working in either stage. Neither do I feel any particular emotion during the process, I am just intent on what I am doing. There are rarely distracting thoughts that could take my mind away from the work. Emotional satisfaction comes after the work is done and I am no longer working or in flow.

The experience of healing

Early on, I began to do public readings of essays that I had written. Most were about my experience of mental illness. Some of the readings were for hundreds of people. Throughout my lived experience of mental illness, I had been intent on not publicly being identified as having schizophrenia. I was acutely aware of public perception of the mentally ill and the stigma attached to having an illness. When I was invited to write and read on the subject, despite my anxiety, I agreed, at least partially, because others would be stepping up and doing similar things with me.

In 2014 I was invited to read at an event in St. Thomas, Ontario. I had grown up in St. Thomas and left there immediately after becoming aware that I was ill. The event was attended by approximately 400 people. I assumed that there would be a few people in the crowd who remembered me or knew my family and I was anxious in the extreme. I used mindfulness meditation to prepare for the event. What I found was that I was well received, and people responded well to my story. At the social time afterward, there were many kind words. I had faced my fear and been welcomed in my hometown. The experience was repeated wherever I read about mental illness. My confidence grew and my fear of the stigma of mental illness diminished. I also noticed a change in my relationships. I was more relaxed and open with my friends.

During the process of public readings and published writing, I also developed closer ties to some of my family, my brothers and sisters. I shared what I was doing with them, initially through Facebook, and they began to encourage me and follow my progress. I had grown up apart from most of my family and welcomed their interest. They have copies of most of my published works and respond positively to any new project that I

inform them of. I've found this change to be healing as well, as most of the time I felt isolated from family. I also now spend Christmas Day with my oldest brother's family in St. Thomas. In previous years I had spent Christmas volunteering at a drop-in centre or alone. I discovered a new phase in my life, a 'healing' experience expanded on by Forgeard et al (2014) thus:

> This phenomenon is most commonly referred to by scientists as post-traumatic growth (the term used in the present review), growth through adversity, stress related growth, or benefit finding, among other terms (Jayawickreme et al.,2012; Joseph and Linley, 2005; Tedeschi et al., 1998). Research in this field has evidenced at least five domains of growth following stressful life experiences: interpersonal relations, the identification of new possibilities for one's life, personal strength, spirituality, and appreciation of life. (p. 329)

While learning to write and doing public readings, my personal spirituality also developed. I had committed myself to a traditional, Catholic spiritual practice about the same time I began to write and as I progressed with writing, I added elements of mindfulness practice and stoicism. My spirituality has become a source of strength, balance, comfort, and confidence. I also began to set goals for myself. I was determined to become as good a writer as I was capable of and to that end I undertook to obtain a professional certificate in creative writing from Western Continuing Studies, in London, Ontario, which I completed in October of 2016.

Currently, I co-facilitate a writing group for anyone who is, has been, or is at risk of being homeless. We do writing exercises each week. The exercises are a mix of fiction writing and true-life experiences. I share my passion for writing and on occasion my experiences to date. I continue to write on my own with an eye to being published, although I would continue to write without publication. It is something that drives me, and I feel very motivated to keep at it. I try various genres of writing. I have had two children's stories, two fiction pieces, three memoirs of essay length, and one-character piece published in magazines. One poem has been well received as well. Now I am writing this essay for this journal. Writing has been a source of healing and growth for me. I am committed to it and when circumstances allow, I share my journey with others.

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Invited Introductory Comment to Two Stories

Stories Speak to the Heart of Matters

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Human beings use narrative to make sense out of their world and themselves, and to tell others about their discovery (Rossitor, 1999). Our stories are narratives of events in our lives that are shaped by our positionality and our cultural context (Butterwick & Lawrence, 2009). Stories can help us to make something meaningful and coherent about what has happened. The aesthetic quality of a narrative relates to its ability to affect our senses, bring about a reaction, and incite dialogue. When listening to stories, the audience is asked to slow down their perception, reflect on what they hear, think, and feel, and ask the question, whose world view does this story represent?

Stories about the Everyday World

Transformative learning, a major research area within adult education, examines how adults experience fundamental changes in perspective (Mezirow, 1978). Storytelling can support the process of transformative learning through three elements: embodied practice, sharing stories about lived experience, and telling stories as a rehearsal for change (Butterwick & Lawrence, 2009). When an individual publically tells a story about their lived experience with mental illness, it is an act of disclosure. Public disclosure is critical to challenge paradigmatic assumptions related to mental health (Brookfield, 2011). If the story gets the attention of others, it can open up the conversation, and spark further growth in perspective. Stories can tell things about the everyday world that otherwise might never be perceived. Increasingly, creative and imaginative approaches, like telling and listening to stories, are happening to supplement critical reflection as a means of deepening understanding or even triggering transformative learning (Dirkx, 2006).

Harry's Story

The following stories are written by Harry Kuhn, an individual who explores a narrative approach with a community-based writing group in London, Ontario. Grit Uplifted, was created to encourage self-expression among writers and to build trust and community for people who have experienced or are experiencing homelessness. Writers meet at the downtown library for weekly education sessions which start with personal writing and follow with group dialogue. The writers share their stories with others in the group and have conversations about each other's work. Harry says, "The support from other writers and the discussion that takes place provides validation of his work and helps to build his confidence". He declares further authorship of his work by sharing his writing in public. Harry says, he does so, "because people seem to like it".

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A Crazy Life: Finding My Compass

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When I arrived in London I was in serious distress internally. I had spent almost ten years trying to live unaided with schizophrenia and it had been an awful experience. I had managed to obtain work making deliveries for an office coffee company, but within a year I had been hired three times and fired three times by the same company. I had the skills and experience to do the job, but was unable to do it with any consistency and the company would get frustrated with my performance and fire me. The problem for them was finding someone who could step in and do the job right so they would rehire me then fire me again. I cannot complain, they gave me every opportunity to show improvement in my work, but I was just not able to do it. I went on Employment Insurance and then to Ontario Works. If I had not already been living in subsidized housing at the time, I would have been in even greater straits. I have learned through many influences to control my illness.

Early experiences with seeking control

Outwardly, people normally did not realize that I was mentally ill unless I told them. I rarely admitted to anyone how I was struggling. I had learned during the ten years of dealing with schizophrenia to be very self-disciplined when dealing with people, but also to retreat from everyone when I felt I could not cope. In my past I had lived in St. Thomas, Ontario, after moving to Ontario from Nova Scotia with my brother's family. As an adult I became involved in the Charismatic Renewal there. It is like the Born Again Christian Movement, but the Catholic flavour. I had changed my life significantly after being in the movement for a short period of time. I had let go of my friends, most of whom were drinking buddies, and became active in my parish. I started going to university, taking courses at night while still working during the daytime. I completed both sociology and psychology courses without a great deal of trouble and was starting a course in logic when my world changed forever. The man who had inspired me to change my life, take risks based on faith and had guided me through a variety of emotional and social challenges to what was happening in my life, died. Something broke inside me. I wept, not just grieving as one might expect of losing a friend and mentor, but literally wept with the deepest sorrow I can remember ever experiencing and a number of times I could do nothing but cry.

My thoughts changed then. I began to feel not a part of the community I had belonged to at my parish. I began to doubt whether I had any real faith of my own and I was anxious most of the time but unable to decide why. I felt so very alone and at the same time unable to reach out and tell anyone I was struggling. I looked back at my life, how I had lived, and could remember the strange fears I had had at times during my time in the renewal and how my mentor had had to reassure me often. Patterns in my own behaviour began to show and my anxiety became full blown fear that there was something wrong with me. But I could not bring myself to tell anyone or ask for help. I turned to my psychology texts and found the answer in abnormal psychology. Not only what I was experiencing at that time, but many of my thoughts and behaviours that had been present earlier in my life fit one type of illness-- schizophrenia. That label horrified me. I doubted my whole experience of the 'renewal' and the experiences that had motivated me to risk coming so far out of my comfort zone. I believed everyone I knew would shun me if they knew. Terrifying ideas of being sent to a mental hospital and never again being treated as an equal or taken seriously, even by family, flooded my imagination. I mistrusted everyone and was hypervigilant with people for

any sign they were aware of, or even suspected, my trouble. Falling apart emotionally I fled St. Thomas.

My first stop after leaving town was the Rocky Mountains in Alberta. While working at a resort as a dish washer I decided to reclaim some of my confidence by climbing a modest little mountain. I had through most of my youth been an outdoors person, camping, hiking, training with the militia. The climb should have lasted a day; three hours up and two to get back. Three days after climbing the mountain I was rescued by helicopter as I had become stranded. I was not in bad shape physically, but emotionally I was shattered. Something which should have been well within my experience and skills had turned into a disaster, and a very public one as the search for me had been in the news. I could not shake the fear that my failure on the mountain was a sure sign I was damaged mentally, and I spent most of the summer believing that everyone I worked with knew it too.

The Toronto years

After a six-month span of traveling, both in Alberta and a visit to the east coast, I stopped briefly in St. Thomas again. Out of work and couch surfing, and even more suspicious of everyone than when I first left, I knew it was not my home anymore. I moved to Toronto and after a brief search found work as a security guard. I had become an obsessive type worker. It was not enough for me to do the job as well as everyone else, I had to do it better, I needed to prove to myself and to everyone else I was okay. But I was not okay. I came to believe that most of my co-workers disliked me and were actively trying to discredit me and I spent a good amount of mental energy attempting to stay one step ahead of them. My attention to detail was extreme as I believed I might be tested at any time. Every challenge, real or imagined, had to be met head on.

When not working I kept very much to myself. I slept little and spent most of my nights actively trying to anticipate troubles I might run into at work or with family. I had convinced myself that no one would take the word of a schizophrenic over a healthy person and agonized over every and any sign of anyone being against me. I saw threats everywhere. A good night's sleep was two hours, three at the outside. There never seemed to be any relieffrom the anxiety. I was in survival mode with no plans or goals, just to get by another day.

When the stress of one job became too great for me, I would quit and rest a week or two then find another

job. I never had trouble finding work it seemed. At age 31 and after almost a year and a half in Toronto, I met a woman and we married. Shortly thereafter I started a new job as a delivery driver for an office coffee company. She seemed to sense my weaknesses, without knowing exactly the nature of my problem, but I worked steady and did my best to provide a life for us. The marriage turned sour after several years, and she used her awareness of my problems to exert some cruel pressures on me for the last few years of the marriage. I refused to give up on the marriage, though, and continued on struggling at work and dealing with her at home for years. I was not prepared to admit failure, even though it had become unhealthy for both of us. One day I came home from work and there was a note on the kitchen table that she had gone to find her own place. It is curious how even being locked in a relationship with someone who gradually grows to hate you seems better than admitting failure and being alone again.

As my marriage grew closer to breaking up, my ability to deal with my work fears grew worse. At times I was near just giving up and once almost broke down in the lunchroom. I was still dealing with all the paranoia about my co-workers that I had experienced on other jobs, but the stress at home was crippling me. Once alone again, my paranoia reached new heights. I began to see threats on the faces of people I believed were following me, but in reality, I had never seen before. When I entered businesses, I overheard comments from people who worked there about how weird I was, even though they had never seen me before, and when I looked around no one actually seemed to be paying any attention to me at all. I was back to not sleeping at night and it took all my energy to just get through one work day. Physically the job was not that demanding, but the mental effort it took was exhausting. Then, one day, I lost it. It was like an emotional crash. Almost everyone I saw while doing my route looked suspiciously familiar and dangerous to me; the last few years of stress during my marriage; my feelings of inability to cope and that there would never be a life for me; the raging fear and anxiety. I pulled my van into a parking lot and phoned my manager. Barely holding back tears and my voice trembling I told him I could not finish. I did not trust myself to drive.

The move to London and rehabilitation

I knew only one person in London when I moved here from Toronto. She was a former teacher and friend who I'd stayed in touch with since high school and a good

person to know. I had, at her suggestion, been volunteering at the Sisters of St. Joseph soup kitchen on Saturdays and, being unemployed with time on my hands, I took on more volunteering activities. I had also become a patient at the London Intercommunity Health Centre (LIHC) and was taking meds for my illness and seeing the psychologist there for counseling. I also joined the LIHC Men's Group and volunteered some time during the week in their office. Briefly, I volunteered at a nursing home where I kept score for the residents' games once a week. Eventually I streamlined my volunteering to just one outlet: The London Coffee House. Privately, I had no goals for myself and my free time was spent in coffee shops. But at the London Coffee House I met many people. Over 11 years as a volunteer there, and casual paid help making coffee each day, I heard stories of things that I am sure would have crushed me but were taken in stride by the clients. There were those with addiction issues, homelessness, mental illness, some just temporarily down on their luck. The kindness and caring attitude of the staff made the coffee house a second home for me and I was there most evenings during the week.

During my time at The London Coffee House I was approached by a board member from my own landlord. I was asked if I would consider moving to one of their residences as a support person for tenants with disabilities. I asked if I would need references and was told yes. It seemed everyone I had volunteered with during my time in London was willing to write a reference.

I had been doing my best to go out to people, but my focus had always been to work on my internal issues and establishing a healthy life for myself. That I had gained a good reputation while doing it was unexpected. I have been in my support role now for 12 years, but have not volunteered at the Coffee House for the last few of those. I still occasionally visit there. The tenants here have welcomed me in and together we have become a very social, almost family like, community.

While acting as a support person at my apartment building, I had been meeting with a Catholic priest once a month for counseling. With his blessing, I committed myself to a very traditional, Catholic, Marian spirituality in the winter of 2012. About the same time, I took an interest in writing and began to experiment with simple exercises. In June of 2012, I joined a writing group (Appendix A).

I still experience symptoms from time to time, but nothing so severe as when I was untreated. At times I struggle too, but I can, and do, turn to people who support me. While I am more relaxed and socially comfortable with my illness, I have, still, a lot of work to do. It feels like my work now is to rebuild myself on the inside and I am gradually making progress with that. The rest of the time I am learning what my limitations are and looking for ways to do what I can with that knowledge. I have developed a sense of humour about some things I did while ill in the past, things I said or thought. Mostly though, I know who I am now.

Appendix A

The Grit Uplifted Creative Writing Group

The Grit Uplifted Creative Writing Group is in its 10th year. Sponsored by the London Intercommunity Health Centre, it meets on Saturdays at the London Public Library, Central Branch, in its 3rd floor boardroom. The focus of the group is to give a creative voice to people who are, have been, or are at risk of being homeless. It is a forum for them to tell their stories, real or imagined. The core of the group is six people who attend regularly, but numbers range up to a dozen at times. Some people stop in once out of curiosity, others come and stay for months. The sessions run for 14 weeks at a time with approximately a month off between winter, summer, and fall sessions. Each session is 2 hours long running from 2 pm to 4 pm. Each session allows about a half hour for personal check-ins; folks say how their past week has gone and talk about any writing they have been doing. There is a theme for each week which is focused on writing stories. Themes can be character, setting, description, dialogue etc. The University of Western Ontario has sent students from one of their literature courses to do placements with the group, and a journalism student wrote a piece on the group for the Western website. Poetry London sent a writer to do a short piece on the group and regularly asks for poets to read at their events. Grit Uplifted has a website to publish writers' short pieces and also a Facebook page. Harry Kuhn facilitates the group along with Meg Pirie. Meg is the lead facilitator but is taking time off at present. Everyone is welcome at the group, homeless experience or not.

Invited Submission

'Writer' – A Discovery

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I am a writer. This is a bold statement for me. For most of my life I would have said "I am a schizophrenic." That's because I thought my illness defined me. I inhibited myself from making close friendships or contacts because I believed if the truth about my illness became known, I would be shunned and rejected. Consequently, even though I was often complimented on how well I dealt with people, I was emotionally isolated and spent most of my time alone.

The first experiences

In the winter of 2012 I took an interest in writing. At first not much more than a few descriptive paragraphs. I shared them with a friend of mine, who I had known since high school, and she encouraged me to keep at it. She thought there was something good about what I was doing. I had my doubts, but I was interested in the process of writing and kept at it. In the summer of that year I joined the Grit Uplifted Creative Writing Group. The group is oriented to people who are, have been, or are at risk of being homeless. In the beginning, I was very quiet in the group. I would do the writing exercises, but I would not read out loud as most of the people did. Gradually, over time, I wrote some pieces about my unhappy childhood and troubles growing up and I read them to the group. I was nervous each time, but the writing was accepted and supported positively. It had a therapeutic effect on me. A lot of tension I had been carrying around for most of my adult life was eased by sharing those experiences and I grew more confident. I began to participate more in the group and read out loud regularly.

About the time I joined the 'Grit' writing group, I completed a short memoir story about a happy remembrance of childhood. My friend liked it so much she encouraged me to submit it to a magazine. It made me anxious to think of sending it out, but I did. For a while I was preoccupied with anxious thoughts that there was no way my story would ever be accepted. Over time I thought less and less about it.

A closely guarded secret

In the fall of that year, a lady who runs an organization called The Healing Palette came to the writing group and asked for submissions to an art show she put on each year. The event included public readings at the opening of the show. She preferred the writing be oriented towards mental illness. Up to that time I had not written about my illness. I was still keeping it a closely guarded secret. I decided to write an essay about my experience of schizophrenia. There was no way I was going to read it, though, and I asked our group facilitator to read it at the event. As it turned out, the piece was too long so only a portion of it was read out loud. The show was held in the atrium of the general hospital in St. Thomas, Ontario, and I went along to witness the event but kept in the background. Our group facilitator told me afterwards that hospital staff, who had read the whole essay, had expressed an interest in meeting me, but nothing came of that.

Later that fall I took part in a Grit Uplifted Magazine launch event at the London Intercommunity Health Centre. We were asked to bring stories that we could read to the crowd. I had a story about a medical trip I had made to an emergency ward one evening that did not go as expected, so I read that to them. I was so nervous that an acquaintance - who was sitting at the back of the room - when I told her after I read that I had been nervous, said that my voice did not sound nervous but she had noticed my left-hand shaking. I was excited to have done my first reading, though.

The following January I was awakened one morning by a phone call from the editor of More of Our Canada magazine. She had read and liked the story I had submitted the previous summer and wanted to publish it in their March issue. I was ecstatic. I had almost forgotten about the submission. I was reluctant, at first, to tell anyone because I thought that something would happen and they would change their mind and I would end up looking foolish. But it was published as the editor had said.

That spring, with the help of my psychologist, I was tutored in English grammar by a university student. We spent about two months meeting once a week. That went well and I felt more confident in my writing afterwards. During the summer months I continued with the writing group. That fall I read again at the London InterCommunity Health Centre (LIHC), a story about my misadventures mountain climbing in the Rockies. My long-time friend attended and the reading went well. I also agreed to write again for The Healing Palette in St. Thomas. This time, though, I would read my own story.

I had grown up in St. Thomas and moved away in my late twenties. The prospect of returning there and reading a story about my having schizophrenia was nerve-wracking. I felt I wanted to do it, but had many fears about a bad reaction from people who knew me or knew my family. Our new facilitator for the writing group would also be there to give moral support, but I was anxious in the extreme. As it turned out, the only person there who knew me was my family doctor and he was excited about how well the story was written. So, for about a week, I felt a buzz of excitement at having faced my fear successfully. I was growing more confident and less inhibited about my illness.

In the winter of 2014, the Western Ontario Community organization was merging with the Canadian Mental Health Association. The day before the gala event, I was asked by my social worker if I would read a story I had written at the event. There would be about three hundred people there, including representatives from three levels of government. I was anxious but agreed to do it. The crowd was closer to three hundred and fifty people, but the reading went well, and the response was a little overwhelming. I found that after the formal proceedings and readings, as I made my way through the crowd, I had to keep my eyes on the exit and moved steadily in that direction until I could leave. It felt more like I was escaping.

The following month I was invited to read the same story in St. Thomas for the 'Clara's Big Ride' evening. Again I agreed immediately. There were approximately four hundred people packed in the atrium and mezzanine levels of the St. Thomas Elgin General Hospital. By this time, I was preparing for readings by using mindfulness meditation. It helped me keep from getting distracted when I was anxious. I read for the event and it went very well. At the end of the event Clara approached me and said she would think of me when she looked at her watch (the story had been an extended metaphor comparing myself to a second-hand watch I had bought).

Me: a facilitator?

Shortly before those events I had begun to fill in as a facilitator for the writing group when our facilitator could not be there. I lead the group through themes related to writing and planned exercises for everyone which I also did with the group. Before each session I was nervous but doing things that made me nervous had become a regular thing for me. The experience also boosted my confidence further. I was more at ease talking and sharing with a group. That fall I read for the LIHC's anniversary event for about two hundred people. Again, my reading was well received and again I was anxious but went ahead with it. I also read again for 'The Healing Palette'. By this time, I had developed a method to my writing. I would have an idea, usually from past experiences, sometimes suggested to me, and I would begin to obsess over it. Without having the full story clear in my mind I would sit one night and begin to write, either on paper or on my computer. If on paper, I would write the idea out then edit it as I copied it into a document on my personal computer. If I went straight to the computer, then I would stop and edit as I went. These writing sessions lasted all night sometimes, but when I was done the piece was close to its final form. I would then try to leave it alone for a few days before rereading it. Often, initially, I did not have a place in mind to submit the writing. I was just intent on getting the final form as good as I could get it. Some of my published pieces sat with me for over a year before I submitted them. Once submitted I was beset by anxious worrying about the quality of the work until I heard from the prospective publisher or received approval from the person I was going to read for. Each successful piece of writing encouraged me to try more and sometimes different writing. They also gave me more confidence in dealing with people in general.

I formally volunteered with the LIHC to be a facilitator with the 'Grit Uplifted Creative Writing' group shortly after the anniversary event. With encouragement from my psychologist, I also enrolled in a fiction writing course with Western Continuing Studies that was to begin in January of 2015. Just as the course was about to begin, while I was struggling with my insecurities about not being the calibre of writer other students would be, I received word from More of Our Canada that they were publishing a second story of mine, a childhood to adult memoir, that I had submitted. They also asked me to write a short children's story for the magazine. I got excited and the timing boosted my confidence to start the course. I decided, despite lack of funds, that I wanted to complete the Professional Certificate in Creative Writing with Western. It would require me to take six courses, one a mandatory grammar course. I approached the LIHC and CMHA and proposed that if they would sponsor me for courses, I would be willing to write for them upon completing the certificate. They agreed and along with help from my psychologist, all six courses were funded for me.

In the summer of that year I began to facilitate every session of the writing group as our main facilitator went on maternity leave. During the fall and winter of the following year I facilitated alone. I also had a story about my misadventures mountain climbing in my late 20s, published in Canadian Stories Magazine in December of 2015. 2016 I spent facilitating the writing group and completing the courses for the certificate. At the end of October 2016, I received my certificate from Western University.

In 2018 I have had another children's story published in More of Our Canada magazine and two more stories, one a short fiction and one a character piece about a homeless man I knew, published in Canadian Stories magazine. I continue to facilitate the Grit Uplifted Creative Writing Group along with our main facilitator.

And yes, I now call myself a writer. It still seems bold to me. Perhaps it always will. I have to overcome my tendency to keep emotional distance from people who might become my friends. Keeping that distance was always a safety thing for me. It kept me from getting hurt. Now it just contributes to loneliness. My current psychologist says I am symptom free and my schizophrenia seems to be in remission. It needs to be maintained with meds and counseling, but he says I am doing well. Writing has played a major role in reaching this point in my journey. And meeting good people.