Shifting from agency to community: Exploring the impact of a community connections program for mental health recovery

Julie Ostrom, B. RLS

Master of Arts in Applied Health Sciences
(Leisure Studies)

Under the supervision of Colleen Hood, PhD

Faculty of Applied Health Science, Brock University

St. Catharines, ON
Dedications

I dedicate this work to my incredible research participants for sharing their life experiences and a piece of their recovery with me. Thank you for trusting me and believing in me during this process. You are all incredibly strong and inspire me to live life with a grateful, open heart.

I dedicate this work to the millions of people who live with mental illness. To those who feel like they are alone, to those who feel like they do not have a voice, please know that you are never alone, your voices can be heard and need to be heard and there are people in this world who want to see a better tomorrow for all. I hope this research shows the power of speaking out for what you believe in and advocating for yourself to see positive change in the mental health system.

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Abstract

The purpose of this project was to explore clients’ experiences of the Community Connections program, an outpatient mental health program in a clinical setting to determine the effectiveness of the program for mental health recovery and community integration. The common themes from the various forms of data collection suggest that (1) the program was effective in enhancing the clients’ self-awareness, (2) the program effectively taught the clients about leisure and its therapeutic benefits for mental health recovery, (3) the program taught clients about the importance of the use of leisure as a way to integrate into the community, and (4) the clients believed that the program could be improved by providing more of an experiential component to teach skills for community integration. While the program taught the clients important lessons that they have used or will use throughout their mental health recovery, the clients identified some areas for improvement that could help future clients experience successful community integration. Additionally, this research design produced an effective model for comprehensive program evaluations that integrate program design with service using prevalent principles of therapeutic recreation practice. This research supports the growing literature that suggests that leisure and therapeutic recreation can be beneficial tools for clients to understand as they progress through their mental health recovery and prepare for community integration.

Keywords: mental health, recovery, therapeutic recreation, leisure, community integration
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CHAPTER ONE: INTRODUCTION

Mental Illness and Mental Health in Canada

According to the World Health Organization, “mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community” (World Health Organization, 2014, para. 1). Mental illnesses, on the other hand, are characterized by alterations in thinking, mood, or behaviour associated with distress and impaired functioning, and develop from interactions between genetic, biological, personality, and environmental factors, such as family history of mental illness, age, sex, substance abuse, chronic diseases, family, workplace, and life event stressors (Public Health Agency of Canada, 2015). Approximately one in five Canadians will experience a mental illness in their lifetime, and the remaining four will know someone, whether it is a friend, family member, neighbour, co-worker, or others who will experience a mental illness in their lifetime (Mental Health Commission of Canada, 2013).

There are various types of mental illnesses, including mood disorders, anxiety disorders, schizophrenia, personality disorders, eating disorders, substance dependency, and problem gambling (Public Health Agency of Canada, 2015). Mental illnesses have the potential to impact every aspect of an individual’s life, including relationships, work, education, and community involvement, and the degree to which a mental illness impacts someone’s life can vary from one person to the next (Public Health Agency of Canada, 2015). With this high prevalence of mental illness in Canadian society, it is important that citizens understand the implications of living with
a mental illness on micro and macro levels in society, such as family dynamic, relationships with friends, families, and neighbours, the work force, educational systems and healthcare systems. In addition to understanding these implications, it is important to develop effective rehabilitation services and tools for recovery to help people living with mental illnesses, and in turn enhance the various systems listed above.

**Importance of Recovery**

It is important to note that treatment is possible for mental illnesses; annually, approximately five million Canadians (or about 1 in 7 people) use services for mental health treatment (Public Health Agency of Canada, 2015). However, providing treatment is not the primary goal of mental health services, the service is meant to support people to use medication or other treatments as a *resource* in their recovery (Slade, 2009). The term recovery has many different definitions based on the perspective one takes when addressing the topic. One of the most widely cited definitions of recovery is cited in Slade (2009):

> Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

As demonstrated from this definition, recovery is the process of changing one’s attitudes, values, feelings, goals, skills, and/or roles from often negative characteristics to positive perspectives that help shift people’s self-narrative from negative to positive. Recovery helps
people to not only see themselves as positive, contributing members of society, but to truly become positive, contributing members of society. Research suggests that “recovery may depend on finding ways of reclaiming forms of power and control, reconnecting with social relationships and finding positive and socially valued identities” (Tew, 2013, p. 363).

For those living with mental illnesses, it can be difficult to manage the symptoms of a mental illness if one does not have the right resources to experience elements of recovery. Traditionally, the medical model which defines mental illnesses as a disease with a physical cause and an identifiable course has been used to treat and identify mental illnesses (Mechanic, 1999). The medical model has viewed mental health as a chronic condition that causes decline in functioning unless there is proper diagnosis and treatment, making the emphasis on expert power and control over clients (Clossey, Mehnert & Silva, 2011). A critique of the medical model is that the criteria for making a diagnosis is not theoretically based, and that people who experience the same illness may display different kinds of symptoms, which would not be considered when using this model for treatment (Mechanic, 1999). In contrast to the medical model, international comparisons suggest that it is social and cultural factors that play a major role in the process of recovery (Tew, 2013). Psychosocial rehabilitation approaches include programs, services, and practices with documented effectiveness in facilitation recovery as it is collaborative, person-centred, and individualized. That is why hospital programs designed to promote recovery and psychosocial rehabilitation are important in society. Government and private practices must implement action plans to aid individuals in the sustainable recovery of mental illnesses so that individuals can learn to live well within the limitations caused by mental illness. There are five major components of recovery that are important to consider in the process of recovery, which
are hope and optimism, empowerment, identity building, connectedness, and meaning in life (Leamy, Bird, Le Boutillier, Williams & Spade, 2011; Ralph & Corrigan, 2005).

**The Recovery Philosophy in Mental Health**

The recovery philosophy in mental health looks at people who have mental illnesses through a lens of hope and possibility rather than through deficits and limitations as the medical model suggests. According to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services (2005), the recovery philosophy is defined as, “a recovery-oriented system of care that identifies and builds upon each individuals’ assets, strengths, health, and competence, and helps people achieve a sense of mastery over their condition while regaining a meaningful, constructive sense of membership in the broader community” (Anderson & Heyne, 2012, p.4). In the allied health field, the philosophy of recovery is looked at with high praise as it values the dignity of the clients as human beings and agents in their process of recovery (Clossey et al., 2011; Fardella, 2008).

As suggested by the definition, the recovery philosophy aims to identify and build upon people’s strengths to help them achieve a sense of mastery over their condition while helping regain a meaningful sense of self in the community and within themselves, reaching those five components of recovery. Psychosocial rehabilitation services build upon individual’s strengths and skills to support them to access the resources they need to live successful and satisfying lives at home and in the community, which is closely related to the values of the recovery philosophy. An effective way to practice the recovery philosophy and psychosocial rehabilitation is using leisure.

**Importance of Leisure in Recovery**
Leisure’s ability to promote meaning-making and purpose in one’s life is highly documented in the research literature (Iwasaki et al., 2010). Research from Iwasaki (2008) presented ways in which leisure pursuits can promote a meaningful life while coping with and healing from stressful or traumatic situations to reduce suffering, and enhancing positive experiences by “… promoting life satisfaction and quality of life by addressing positive emotions, identities, spirituality, connections and harmony, human strengths and resilience, and human development and learning across the lifespan” (Iwasaki et al., 2010, p. 485). The form of leisure is secondary to the meanings derived from the leisure experience, and the potential that these meanings have in aiding people in their mental health recovery. For example, leisure has the ability to form meaningful engagement in one’s community, which can aid people in their mental health recovery.

Community Engagement in Recovery

As noted above, one of the main components of recovery is connectedness, which is feelings of support and belonging with family, friends, community members, and the systems within the community. The idea of recovery being an ecological process, defined as the interactions between a person and their social and physical environment, is a fairly new idea and there is a gap in the research literature regarding recovery as an ecological process (Yates, Holmes & Priest, 2011). In one literature review that attempted to find ecological themes within the recovery literature, there were four main themes that represented the data on recovery, but the two themes that relate to this study were 1) place, social context, and identity, and 2) social connectedness (Yates et al., 2011).
“Identity was associated with group membership formed within a place and around an activity” (Yates et al., 2011, p. 145). Places that were considered “normal” such as community venues were associated with positive identity, whereas psychiatric spaces were seen as holding an illness identity (Yates et al., 2011). Additionally, the research literature found that being in a social group where an individual has meaning and the people in the group value and support the individual is also associated with positive identities that aid in recovery (Yates et al., 2011).

Regarding social connectedness, research from Mezzina et al. (2006) found that “supportive environments such as clubs, churches, day centers, and support groups were overall experienced as being beneficial in terms of reducing isolation, aiding socialization, and challenging stigma…” (Yates et al., 2011, p. 146). Being connected to a community through leisure is a great way for individuals to re-build their identity in a positive manner, socialize with members of the community, gain confidence and competence as a beneficial, valued member of society. Additionally, being connected to members of a community and having opportunities to connect to systems within that community contributes to the reduction of social stigma, as well as self-stigma. Being connected to the community through leisure also allows individuals to develop positive connections to places and people outside of hospital services. Based on these themes and others that will be explored later in this paper, the need for community engagement and connectedness can be seen as an important aspect of the recovery process.

The Community Connections Program

In 2016, I completed the final year of my undergraduate degree in recreation and leisure studies, with a major in therapeutic recreation. As part of my course requirements and to be eligible for the National Council of Therapeutic Recreation Certification I had to complete a 560-
hour (four month) internship with a certified recreation therapist. I was fortunate when I was offered an internship placement at a hospital in Southwestern Ontario in the outpatient mental health unit. Part of my internship requirements was to complete a special project to contribute to the organization. It could be anything that we saw a need for in the program, for the clients or for the staff, as long as it was practical and helpful to the field. My partner, Samantha and I were asked to help the recreation therapists create a community transition program to help people successfully transition into the community. The need for this type of program was due to the amount of people who would be re-admitted to the hospital after being discharged from services, and the amount of people who stayed in the program longer than they should. The “Community Connections” program was made with the intent to help people prepare for the transition from the hospital agency back into the community feeling more autonomous and confident during the next stage of recovery.

With that goal in mind, Samantha and I brainstormed different aspects of recovery and independent living that were important to help people make their transition and recovery more successful. Topics such as goal-setting, volunteering, social support, and personal strengths were discussed as important connections and qualities to address in the sessions. With the mentorship of our supervisor and the other recreation therapist in the unit, we developed an eight-week program with information, activities, assessments, homework activities, and discussions to address different learning styles for the clients to not just learn and understand, but practice and relate these topics to their own lives and recovery.

By the end of the internship, the program was complete and approved for use in the hospital for the recreation therapists to integrate into the outpatient mental health program. Since then, the program has been implemented multiple times with success in each session. I was so
excited to hear that the program was going well and that clients were appreciating the program, but it also made me curious, what was it about the program that was benefiting the clients? Was it the strength-based model? Was it the topics we covered? Was it the activities and program layout? If this program was working for the clients at the St. Catharines hospital, could it work for clients in other hospitals? Could this program build on the conversation about successfully transitioning from agency to community? So many questions came to mind when I thought about the success of the program and the potential implications for mental health services in Ontario, that I decided to dedicate my master’s research thesis to answering these queries. With these queries alongside the above literature framework relevant to recovery, my aim with this study is to understand the needs for clients to successfully transition back into the community and recover from mental illness through the use of the Community Connections program, while also conducting an evaluation of the Community Connections program to help inform future programming at the hospital.

**Rationale for the Study**

The premises that support this project include (1) the understanding that recovery is a process, (2) therapeutic recreation and leisure practices can support the process of recovery, (3) one indicator of recovery is community engagement, and (4) the Community Connections program supports the process of recovery and becoming engaged with the community through therapeutic recreation and leisure practices. To help achieve the process of recovery and mitigate some of the barriers to recovery, the Community Connections program aims to help individuals develop a positive sense of self, and a sense of agency so that they can believe that they have the personal ability and the resources to achieve recovery in the community, as well as developing a sense of security and a positive sense of place in the community as opposed to in the hospital.
Other benefits of this study include a more in-depth understanding of clients’ experiences with mental health recovery and rehabilitation services for the practitioners to understand their clients’ wants and needs when they are going through the recovery process. This information can help inform the services that practitioners give, as well as their approach to rehabilitation services so it is more meaningful and sustainable for the clients. From a societal level, this research can help inform the community of the needs of individuals who are re-integrating into the community. Stigma occurs at all levels of society, so it is important to spread awareness of people’s experiences to eliminate this stigma and create more accepting and inclusive environments for all members of society.

**Research Questions**

Considering the prevalence of mental illness in Canada, the need for recovery-oriented services, and the value of leisure and community engagement in recovery, I have developed the main research question: What are the clients’ experiences of the Community Connections program?

Additionally, the following sub questions will be explored throughout this research project:

How does the Community Connections program effect clients’ recovery process?

How does the Community Connections program support skill development for community integration?

How does the Community Connections program shift clients’ perspectives about engaging in leisure in the community?
The chapters that follow will further explore the research literature regarding the impact of mental illnesses, recovery, mental health services in Canada and the transition from care to community, the role of leisure and therapeutic recreation in recovery and further explain the Community Connections program. The methodology chapter will explain the epistemological lens used to inform this research project, the various modes of data collection and methodologies that will be used, and considerations for trustworthiness and ethics to ensure this project is reliable, valid, and safe for all who will be involved. The results chapter will report the various findings and common themes from the research study. The final discussion and conclusion chapter will explore the common themes more in depth with support from the research literature, reflect upon my personal experience throughout the research process, discuss limitations of the study, and give recommendations for the future of the program and future research.
CHAPTER TWO: LITERATURE REVIEW

The literature review will outline the main theories, concepts, and the program that will be studied for this research. This review will further explore research literature regarding the impact of mental illnesses, recovery, mental health services in Canada and the transition from care to community, the role of leisure and therapeutic recreation in recovery and end with a summary of the Community Connections program. Understanding this literature will help inform my research project and answer my research questions listed above.

THE IMPACT OF MENTAL ILLNESS

The Cost of Mental Illness in Canada

According to the Centre for Addiction and Mental Health, “the economic burden of mental illness in Canada is estimated at $51 billion per year, which includes health care costs, lost productivity, and reductions in health-related quality of life” (Centre for Addiction and Mental Health, 2017, para 4). In 2008, the direct costs (i.e. hospital care, physician care, and drug expenditures) associated with mental illnesses were estimated to be $8 billion in Canada (Economic Burden of Illness in Canada, 2015). In fact, patients who have a high cost mental illness incur 30% more costs than other high cost patients, according to the Centre for Addiction and Mental Health (2017). There are many indirect costs associated with mental illness as well, such as costs for disability claims, loss of productivity at school and work, and social and judicial services (Cohen & Peachey, 2014).

According to the World Health Organization, “more working days are lost as a result of mental disorders than physical conditions” (Centre for Addiction and Mental Health, 2017, para
9), and “the cost of a disability leave for a mental illness is about double the cost of a leave due to a physical illness” (Centre for Addiction and Mental Health, 2017, para 5). A North American survey of organizations that operate for all major industry sections found mental health issues to be the primary cause of short- and long-term disability in Canada (Mental Health Commission of Canada, 2015). Indirect costs are much higher than direct costs, depending on the expenditures included, these costs have been shown to range from $11 to $50 billion (Mental Health Commission of Canada, 2015). As evidence demonstrates, promotion, prevention, and early intervention initiatives can show positive returns on investments related to reducing the impact of mental illnesses in society (Centre for Mental Health and Addictions, 2017).

In addition to financial costs and loss of productivity, there are also many psychosocial costs that impact the lives of people living with mental illnesses. In a study conducted by Merikangas et al. (2007) in the United States, participants reported the number of days in the past month where they were unable to perform their usual daily tasks due to problems related to their physical or emotional health. Those with mental illnesses associated more than half of the days of the month where they were unable to perform their daily activities due to the effects of their mental illnesses. Those who had depression had one of the largest effects on their daily activities of all the conditions included in the study (Merikangas et al., 2007). Mental illnesses cause impairment and difficulties in many areas of functioning, including home life, social interactions, and close relationships (Alan & Stacey, 2011).

Stigma, which is known as a feeling of shame or discredit, is a very common difficulty faced by people who have mental illnesses, from society (social stigma), structurally (institutional stigma) and from within themselves (self-stigma) (Livingston & Boyd, 2010) which can have major implications on psychosocial functioning. Social stigma exists within a group,
when the group endorses stereotypes about another group and acts against that said group. (Livingston & Boyd, 2010). Institutional stigma is based at a systems level within the rules, policies, and procedures of private and public organizations that restrict the rights and opportunities of people who have mental illnesses (Livingston & Boyd, 2010). Lastly, self stigma exists within the self, where the person endorses stereotypes about mental illness to be self-relevant, anticipates social rejection, and considers themselves to be a devalued member of society (Livingston & Boyd, 2010). Other psychological effects of stigma include distress, social withdrawal, secrecy, and reduction in perception of self-worth and self-esteem (Pérez-Garin, Molero & Bos, 2015). Altogether, stigma leads to exclusion and discrimination which affects access to housing, healthcare, employment and social activities (Pérez-Garin et al., 2015). The experience of stigma has been shown to reduce psychological well-being, life satisfaction, and probability of seeking help from mental health services (Pérez-Garin et al., 2015).

The various psychosocial and financial costs of mental illness continue to persist and affect all members of society, not just those who have a mental illness. By providing more sustainable services for mental health rehabilitation and raising awareness of mental illnesses and the effects these illnesses have on society and individuals within the society, we will start to see more necessary changes in policies and attitudes that will be monumental in the equal treatment of all people, and therefore reduce the costs of mental illnesses.

**RECOVERY**

**What is Recovery?**

The term recovery has many different definitions based on the perspective that one takes. Some researchers see recovery as a process, while others see recovery as an outcome. As a
process, recovery refers to learning to approach each day’s challenges, overcome disabilities, learn skills, live independently, and contribute to society (Mental Health Commission, 2017). As an outcome, recovery represents a change from a previously maladaptive state to a position of “normal” living (Mental Health Commission, 2017). This definition has the connotation that reduction or removal of symptoms is a necessary part of recovery which may not be possible for some individuals. Thus, for the purpose of this project, I will use the definition of recovery as a process, since this definition implicates that recovery is dynamic, ongoing, and supports the individual using their strengths and capacities to help them experience recovery. From the various definitions found in the literature there have been common themes that seem to encompass the meaning and elements of recovery with mental illness. As opposed to focusing on the disease or symptoms of the mental illness, recovery focuses on the potential for growth and is understanding and acceptance of one’s mental illness as a part of their life and a part of their story, but not the only part of their story. Recovery means no longer viewing oneself primarily as a person with a mental illness and reclaiming a positive sense of self. Recovery becomes possible when the individual believes that they can recover and live well (Ralph & Corrigan, 2005).

**Components of Recovery**

From a review of the recovery literature, Ralph suggests that there are four dimensions of recovery found in people’s personal accounts of the recovery process (Ralph & Corrigan, 2005): internal factors, self-managed care, external factors, and empowerment. The first dimension, internal factors, are those qualities that lie within the person, such as the insight and determination it takes to recover. The second dimension, referred to as self-managed care, is an extension of internal factors and refers to the ways in which people manage their mental health and cope with difficulties they face. The third dimension, external factors are those supports that
come from other people to aid in recovery such as interconnectedness with others, support from family, friends, community members, and professionals who believe in an individual’s ability to cope and recover (Ralph, 2000). Recovery is not accomplished alone as one’s interactions with their support systems, the environment, the community, the healthcare system, and even sociopolitical variables influence the process of recovery (Ralph & Corrigan, 2005). Research from Connell, O’Cathain, and Brazier (2014) concluded that the concept of belonging, fitting in with society, and quality of relationships was important to quality of life, and identified the importance of caring, loving and supportive relationships, companionship and comradery, together with acceptance and understanding from wider society in reference to recovery.

Lastly, the fourth dimension of empowerment is a combination of internal and external factors that are driven from one’s internal strength and supports to provide hope and belief that the person can recover from mental illness (Ralph & Corrigan, 2005). Further studies support this component of recovery as being an important part of the recovery process. In a review of the personal recovery literature, the theme of empowerment with subthemes of personal responsibility, control over life, and focusing upon strengths was listed in 79 out of 87 studies (Leamy et al., 2011).

Research suggests that hope is one of the cornerstones of recovery (Ralph & Corrigan, 2005). In the same literature review conducted by Leamy et al. (2011), the power of hope and optimism about the future is cited in 69 of the 87 studies. Key themes related to hope and optimism about the future include motivation to change, belief in the possibility of recovery, hope-inspiring relationships, positive thinking and valuing success, having dreams and aspirations, and a positive view of the future. Furthermore, Connell et al. (2014) states the importance of a positive view of the future as necessary to contribute to enhanced quality of life,
which involved having goals and aspirations, and being involved in activities that were fulfilling and had meaning and purpose, which were necessary for initiating change and having hope for a better future.

One important and also challenging part of the recovery process is re-building and redefining a positive sense of identity. In the literature review conducted by Leamy et al. (2011) 65 of the 87 studies discussed the theme of identity and topics related to dimensions of identity, including overcoming stigma and rebuilding/redefining a positive sense of identity.

Kirkpatrick and Byrne (2009) describe the home as an anchor for identity, meaning that the home is a base that enables a person to maintain social roles and have possessions. Relationships that position people within certain identities, (e.g. friends and family) can be helpful as they remind and confirm a sense of stable identity distinct from a psychiatric identity. New relationships are also experienced as aiding recovery through the emergence of other identities such as ‘‘partner,’’ ‘‘husband’’ or ‘‘wife’’ (Kirkpatrick & Byrne, 2009). By building upon these positive identities, individuals can stop thinking of themselves as patients who identify themselves by their diagnosis and start identifying themselves based on their strengths and positive roles.

The last category of the literature review explored the theme of meaning in life during the process of recovery (Leamy et al., 2011), where 59 of the 87 studies cited this topic. Subthemes included meaning of mental illness experiences, spirituality, quality of life, life meaning and social roles, life meaningful and social goals, and rebuilding life. The findings of this literature review promote the importance of rehabilitation services focusing on these components of recovery to build a successful and sustainable life for clients. If rehabilitation services can encompass these themes of internal factors, external factors, self-managed care, empowerment,
hope, rebuilding a positive identity, and meaning in life in the recovery process, the anticipated outcome is that it will enhance clients’ ability and confidence to recover and integrate back into the community. The Community Connections program aims to help clients develop these themes of recovery throughout the sessions, more specifically internal and external factors, empowerment, rebuilding a positive identity and meaning in life, to help them achieve recovery more successfully and continue those positive behaviours after discharge from the hospital services.

The Process of Recovery

Recovery is not an easy process. There are many challenges that recovering clients face when shifting their thoughts, behaviours, and overall identity from patient to contributing member of society. The Stages of Recovery as outlined by Andresen, Caputi, and Oades (2006) explains the emotional and behavioural changes and experiences that individuals encounter while embarking on the process of recovery.

The Stages of Recovery starts with the Moratorium stage. During this stage, people experience uncertainty, despair, and identity confusion, which often results in withdrawal or relapse as a protective mechanism from this confusion and uncertainty (Andresen, Caputi, & Oades, 2006). The Awareness stage is marked by the realization that a fulfilling life is possible within the limitations of a mental illness. The Preparation stage is when people start to consider their strengths and weaknesses in terms of recovery and start to work on developing themselves and their skills so that recovery will become more possible. The Rebuilding stage is when people actively work towards their recovery by building a positive identity, setting goals, and taking control of the symptoms of their mental illness so they can work towards living a meaningful
life. People who are referred to the Community Connections program are often in the Rebuilding stage of their recovery, as they are encouraged to build a positive identity, set goals for community integration, and work towards living a meaningful life. The last stage is the growth stage, where people are living a full and meaningful life while managing the symptoms of their mental illness, and experiencing resilience and a positive self-esteem (Andresen, Caputi, & Oades, 2006). The aim of the Community Connections program is to help individuals work towards this growth stage of recovery.

There are four common processes that occur among these five stages, related to the process of recovery, which are finding and maintaining hope, taking responsibility for life and well-being, renewal of the sense of self and building positive identity, and finding purpose and meaning in life (Andresen, Caputi, & Oades, 2011). These processes are closely related to the Community Connections program by using therapeutic recreation interventions to help people navigate these processes related to their own personal recovery. With a combination of providing resources for clients to become connected to the community, resources to practice self-awareness and personal reflection, and information about growth and recovery with mental illness, the Community Connections program helps clients move on from the preparation or rebuilding stage to the growth stage of recovery so that they are better prepared for living a meaningful life in the community.

These stages of recovery represent the process of recovery as a flexible timeline in terms of when an individual reaches the growth phase. It is important to note the deeply personal and influential emotions involved with the first stage of moratorium, when an individual feels a sense of loss and hopelessness. Moving on from this stage to the awareness stage is a very difficult shift in perspective that often takes people a long time to get a handle on, especially due to the
comfort with what is familiar. When an individual has looked at the world through a negative lens for so long, feelings of positivity and hope can feel close to impossible, and when these feelings are experienced there is often a negative perspective to off-set those positive feelings. Building these skills can take a while, which can be frustrating for the clients who may not be seeing or feeling a lot of changes, but it is important to get them on board with the potential benefits they could experience throughout the recovery process to help keep them motivated and hopeful.

Similar to the Stages of Recovery, the Stages of Change Model describes the behavioural shift that people go through when they want to change a maladaptive behaviour (DiClemente & Prochaska, 1998). The first stage of the model is the “precontemplation stage,” where people typically do not consider their behaviour to be a problem, and often experience denial when hearing about negative consequences of the behaviour or advice to change the behaviour (Munson, Barabasz & Barabasz, 2018). Related to mental illness, people experience many negative symptoms as a result of their mental illness, and eventually these negative symptoms or consequences affect people in a negative way, which leads them into the contemplation stage where the person starts to think about changing the behaviour and what that would mean in their lives (Munson et al., 2018). The preparation stage happens when the person realizes that the change in behaviour is necessary, and they start to take the steps that are required to move them towards their goals for change. During the action stage the individual starts to adjust their behaviour and their environment in an attempt to modify their behaviour. In order to be successful in this stage, individuals must be dedicated, and take the time and energy needed to modify the behaviours that they have become familiar and comfortable with over time (Munson et al, 2018). The last stage is the maintenance stage, which occurs when not only the changes to a
problem behaviour are maintained, but the cognitive gains that were experienced throughout the process are also sustained.

For individuals who are engaged in the Community Connections program, they are presumed to be between the last two stages of the action stage where they are making adjustments to their behaviour and environment and the maintenance stage where they are maintaining the positive behaviours that they have learned and implemented in their lives and the cognitive gains are sustained. Individuals in the Community Connections program are at a point in their recovery where they are preparing to discharge from hospital programs, which means that they are at a stable place in their recovery and preparing to live life independently in the community using the skills they have learned and sustained from hospital services.

It is important to note that many individuals will experience relapse as they continue to cycle through the stages of change and that is accepted and even expected when undergoing behavioural changes (Munson et al., 2018). Everybody’s experience of recovery is different, and everyone will experience these stages within different timeframes, but it is important to support individuals as they go through the stages due to the possible frustration or disappointment that they may experience if they do relapse back to the maladaptive behaviour. If individuals do experience relapse and recycle through the stages of change it is important to ensure that they maintain hope and self-efficacy so that they can continue to build and grow from their experiences until the new behaviour is solidified.

**Barriers to Recovery**

Ralph and Corrigan (2005) state that there are two main types of barriers to recovery, which are external and internal. External barriers are barriers that are imposed by outside forces
to limit people’s possibilities to be independent and fully accepted and/or integrated into society. Examples of external barriers could be social stigma, lack of desirable or safe housing, lack of job opportunities, poverty, segregation, lack of access to transportation, and inadequate resources and supports for people to live more independently with a higher quality of life (Ralph & Corrigan, 2005). Some barriers that were identified as being detrimental to quality of life from their research study were critical and judgemental relationships, stigmatisation, rejection and lack of understanding by people close to them and wider society, all of which resulted in feelings of loneliness, isolation, and detachment.

Internal barriers are personal limitations due to negative beliefs and attitudes about one’s life circumstances, which can be very difficult for someone with a mental illness to overcome on their own (Ralph & Corrigan, 2005). Some examples of internal barriers include negative self-talk, negative self-image, hopelessness, anger or frustration, and overall poor self-esteem and self-efficacy. In a research study, individuals reported how a lack of self-confidence stopped them from doing the things they wanted to do and being the person they wanted to be (Connell et al., 2014). These individuals recognized that if they were able to overcome the barriers that were stopping them from doing the things they wanted and becoming the person they wanted to be that their quality of life would improve, however the challenges they faced and the degree of difficulty they experienced when trying to overcome these barriers had a further detrimental effect on self-esteem and feelings of self-worth (Connell et al., 2014). In the same study, clients stated the detrimental effects of feeling hopeless in the recovery process (Connell et al., 2014). Feelings of hopelessness and despair were reported in clients who had previously attempted to make positive changes in their lives and had failed, and when coping mechanisms that had
previously worked for them no longer had a positive effect. As a result, clients felt stuck and not able to perceive how their situation might change in the future (Connell et al., 2014).

Self-efficacy is an important factor to consider when discussing people’s determination to change behaviour. “Self-efficacy refers to an individual’s beliefs about his or her ability to handle and respond effectively to different situations” (Munson et al., 2018, p. 58). Individuals who have mental illnesses may experience a low sense of self-efficacy due to the difficulty involved with changing behaviours due to symptoms of mental illnesses that are often out of people’s control, or feel out of people’s control. If individuals have a low sense of self-efficacy, they may be more likely to relapse and experience feelings of failure and doubt their capabilities towards recovery. When individuals who have a low sense of self-efficacy experience success, they often attribute it to external factors (Bali, Kohli & Malik, 2017), which is not as effective as attributing their success to their own capabilities, which could be motivating and empowering. When individuals experience a high degree of self-efficacy, they are more likely to take on challenging tasks that are required during the process of recovery, so it is important for healthcare providers to promote self-efficacy and the self-awareness involved with the recovery process (Bali et al., 2017).

With many limitations, it is understandable why and how people experience barriers to recovery with mental illnesses, but with proper support and resources, people have a better opportunity to experience less limitations and more progress towards recovery. The Community Connections program aims to build a positive sense of self identity, a sense of agency and the belief that clients have the tools to experience the components of recovery, and build a sense of security and place within themselves and within the community to help combat these barriers and experience the positive aspects of recovery.
TRANSITION FROM CARE TO COMMUNITY

Mental Health Services in Canada

All healthcare services in Canada are governed by the Canada Health Act, and its objective is to protect, promote, and restore the physical and mental well-being of Canadians while ensuring reasonable access to health services despite limitations such as income, education, or cultural differences (Canadian Civil Liberties Association, 2017). Government funding on the federal and provincial level is required to cover health services that are considered to be medically necessary to maintain health, prevent disease, and to diagnose or treat injuries or disabilities. The scope and coverage of what is considered to be medically necessary has been protested as many services are either unfunded or partially funded. Mental health services are often overlooked when considering these medically necessary services, despite the importance of mental health for one’s overall health and well-being (Canadian Civil Liberties Association, 2017). Many mental health services must be paid for out of pocket or through private third-party insurance, which can cause quite a burden on individuals who need psychological and/or pharmacological resources. Additionally, access to these resources can be limited due to long referral wait times, geographic location, lack of transportation, and social stigma. For these reasons, it is understandable why many individuals choose not to utilize the mental health services that are available to them (Canadian Civil Liberties Association, 2017).

There is a continuum of mental health services available in Canada, including primary care, inpatient care, outpatient care, and community-based care. In Canada, as of 2013, there are 250 programs that meet accreditation standards for mental health programs in hospitals and community-based programs (Mental Health Commission of Canada, 2018). The Mental Health
Commission of Canada reports that only one-third of Canadians who need mental health services actually receive them (2013; 2017). As stated previously, approximately five million Canadians or about one in seven people use mental health services annually to aid in their recovery (Public Health Agency of Canada, 2015).

**Clinical Mental Health Services**

Clinical mental health organizations include hospital services and acute inpatient services where clients can stay in care on a short-term basis when experiencing the unpleasant or harmful symptoms of a mental illness. Various reasons for required clinical care include being unable to care for oneself, experiencing feelings of extreme agitation and thoughts of harming oneself or others, not eating or sleeping for several days, experiencing hallucinations that are beyond one’s usual condition or for the first time, and/or experiencing symptoms that one can no longer manage on their own and that require adjustments to medication that must be monitored closely for several days (Mental Health Commission of Canada, 2017). Referrals for in-patient hospital programs often come directly from emergency psychiatric services.

In-patient services can include close care and observation, stabilization, medical screenings, mental health assessment and diagnosis, co-occurring substance use assessments, individual and group programs for education, support, and counseling, and the development of a discharge plan in collaboration with a community case worker to set up further rehabilitative treatment and community resources. Staff in an in-patient unit can include psychiatrists, nurses, social workers, community case workers, recreation therapists, occupational therapists, physiotherapists, dieticians, spiritual care advisors, peer support providers, and pharmacological support (Mental Health Commission of Canada, 2017).
When individuals have been discharged from in-patient services, they are often referred to outpatient services. When individuals are considered safe and ready to leave the 24/7 hospital services, they can start to attend programs on a weekly basis where they come to the hospital from their homes for a set amount of time for various types of interventions and/or counseling from the staff at the hospital to aid in their recovery. These interventions can include psychosocial interventions, psychotherapy, cognitive behavioural therapy, recreation therapy, and social work, to help improve the overall quality of life and well-being of individuals who have mental illnesses (Mental Health Commission of Canada, 2017).

**Transitional Mental Health Services**

Assertive Community Treatment (ACT) is a client-centered, evidence-based practice that provides all psychiatric outpatient treatment, rehabilitation and support services to persons with severe mental illness, who are most at-risk to frequent relapses, rehospitalizations, and who have severe psychosocial impairment (The B.C. ACT Program, 2018). Clients of ACT often have co-existing problems such as involvement with the judicial system, homelessness, or substance abuse problems. ACT Teams work with clients in their homes, work settings, or in the community where additional support might be needed to promote independence and the ability to utilize newly learned skills in “real world” settings. Some services include dual-diagnosis treatment, supported employment, illness management and recovery, mobile crisis interventions, individual supportive therapy, behaviourally oriented skill teaching, support for resuming education, collaboration with families and assistance to clients with children, and direct support services to obtain legal and advocacy services (The B.C. ACT Program, 2018). Numerous reviews have documented evidence for the efficacy of the ACT model, including reduced
hospital use, increased housing stability, improved quality of life, and may also reduce staff
burnout and client dissatisfaction (Bond et al., 2001; Finnerty et al., 2015; Mueser et al., 1998).

Community Mental Health Services

Professional staff in various fields work in community-based organizations to provide
care and resources to community members who experience mental illnesses. These community
organizations can provide members with information about different organizations and resources
to aid in recovery and maintenance of mental health, as well as counseling and interventions to
assist in recovery at home and in community settings (Mental Health Commission of Canada,
2017). Additional services at the community level include referral, advocacy, case management,
housing advocacy, vocational training and employment assistance, support groups, and social
and recreational opportunities (Mental Health Commission of Canada, 2017).

Some professional positions in community mental health organizations can include case
managers, crisis counsellors, dieticians, housing support workers, mental health promotion
workers, nurses, occupational therapists, physiotherapists, recreation therapists, peer support
workers, personal support workers, psychologists, psychiatrists, rehabilitation workers, and

While there appear to be many opportunities for services in the community, there is a gap
in services for those who are not considered to be most at-risk for severe mental illnesses, or
those who cannot access these resources due to socio-economic and social factors. As stated
previously, the Mental Health Commission of Canada reports that only one-third of Canadians
who need mental health services actually receive them (2013; 2017). Of the people who do
receive mental health services, re-
hospitalization and relapse is very common. For example, from a population of individuals who have psychosis in the UK, “the cumulative relapse rate five years after initial recovery from psychosis is 82% and the second relapse rate is 78%” (Sullivan et al., 2017). This rate of relapse could suggest that the current system for treatment is not effective for long-term or sustainable recovery. There is a gap between the clinical services that people receive and the community services available that should be addressed at both the clinical and community level to ensure that people have access to the resources they need to maintain their mental health and prevent relapse. The Community Connections program that will be examined throughout this research is in an outpatient unit in a clinical setting, with the aim to help prepare individuals for life and continued recovery in the community as an individual.

**Barriers to Discharge**

It is argued that the ultimate goal for mental health services and mental health recovery is to provide individuals with the skills and resources to live independently and to live well within the limitations of a mental illness. It is important that when clients leave a more structured environment such as clinical mental health services, a transition process needs to be in place to prepare the client for the new, more open and freer environment (Belcher & DeForge, 2005). When proper plans are not in place for clients, there is a risk of relapse, rehospitalisation, and possible feelings of low self-esteem, self-efficacy, and the belief that recovery is not possible, which can be damaging in the process of recovery.

Additionally, the fear of stigma can prevent people from wanting to leave the hospital services. When clients are with other people who have mental illnesses and have supports from practitioners and staff who work at the hospital there is a sense of security and a sense of
acceptance for those individuals with mental illness. When clients leave the hospital setting and interact with people outside of this setting, they feel they must make a greater effort to mask the effects of their mental illnesses for self-protection from possible stigmas that may be present in other environments in the community (Connell et al., 2014). In a research study, doubts about how clients fit in society and with how society fit with them were significant barriers that individuals experience when trying to integrate with society (Connell et al., 2014). Feelings of disconnect and feeling different as opposed to not normal influenced the dilemma of whether they wished to be part of society (Connell et al., 2014). That is why the thought of leaving the hospital and integrating with society can be daunting, which can cause people to stay in clinical services longer than they need to, and hold them back from leading a life as an independent and healthy person at home and in the community.

When considering acute or subacute mental health services (short-term stay in a clinical mental health setting), the discussion of readiness for discharge is based on observations of the clients’ severity and persistence of behavioural symptoms, as well as observations, narrative and clinical judgment from hospital workers (McMinn, Lewin, Savio, Matters & Smith, 2017). Clinical progress should be assessed using mandated measures to focus on behaviour in the short- and long-term to prevent rehospitalisation (McMinn et al., 2017). It is important to recognize factors such as family life, social health, physical conditions, and financial, geographical and vocational factors have an important influence on the readiness to discharge as well (McMinn et al., 2017).

Finnerty et al., (2015) who conducted a study on practitioners’ perspectives of the challenges their clients face when transitioning from mental health services to less intensive service, concluded that there are four main domains to consider when thinking of barriers to
transition. These barriers include the client/clinical, family and natural supports, the community treatment staff and team, and the public mental health system. The barriers concluded from this study from Finnerty et al., (2015) include:

beliefs that clients and families would not want to terminate services (due to loss of relationships, fear of failure, preference for the ACT model), clinical concerns that transition would not be successful (due to limited client skills, relapse without ACT support), systems challenges (clinic waiting lists, transportation barriers, eligibility restrictions, stigma against ACT clients), and staff ambivalence (loss of relationship with client, impact on caseload). (p. 85)

Due to the various barriers that clients experience when they reach the discharge phase of their rehabilitation and recovery, it is important to have programs in place to prepare people for discharge and life in the community as an autonomous individual. With the Community Connections program, the goal is to help mitigate the barriers that are experienced throughout the recovery process and help clients develop a positive sense of self, sense of agency, and sense of security within themselves and within the community. One of the goals of the program is to develop a positive sense of self by engaging in self-awareness and reflective exercises as they relate to personal experiences outside of the hospital setting. Another goal is to develop a sense of agency, so that clients can believe that recovery is possible, and believe that they have the internal and external resources to achieve recovery. Another important goal is to shift their sense of security from the hospital to a community setting where they can be themselves, explore their identities, explore leisure and community resources and interact with others in a safe environment.
Strategies for Successful Transition from Agency to Community

In order to help people successfully make the transition from a hospital agency into the community and community care, it is important to highlight successful strategies that healthcare providers and researchers have previously used or have promoted to help make this transition easier and more successful in the future.

One of the most important strategies that was stated throughout the research literature was the development of a discharge plan. A discharge plan is defined as “… an ongoing process that facilitates the discharge of the patient to the appropriate level of care. It involves a multidisciplinary assessment of parent/family needs and coordination of care, services, and referrals” (Noseworthy, Sevigny, Laizner, Houle, & La Riccia, 2014). This process starts from the moment that the patient is admitted to the program by taking time to understand their personal wants and needs and developing a strong therapeutic relationship. Evidence suggests that having a strong therapeutic relationship can be linked to improved mental health outcomes, which can be extended from hospital settings into community settings (Noseworthy et al., 2014).

With the Community Connections program, clients interact with the practitioners from the start of their programming until the time of their discharge. The Community Connections program is one of the last that clients engage in before they discharge from the hospital services, thus giving them more time to develop close therapeutic relationships due to the nature of the courses in the outpatient service program.

Specific strategies to support transition from ACT to less intensive services based on the perceptions of practitioners included “… building skills for transition, engaging supports, celebrating success, enhanced coordination with new providers, and integrating and structuring
transition in ACT routines” (Finnerty, 2015). The Community Connections program helps to build skills for transition by developing the clients’ self-awareness and therein a sense of identity along with skills to better engage in the community. Some skills include finding community resources, developing friendships, making plans for leisure, and goal setting which will help build confidence and ability to engage in the community and further their personal recovery. Additionally, practitioners highlight the importance of the clients taking care of themselves, attending to their basic activities of daily life autonomously so that they can start to experience normal living conditions and be better prepared for those conditions away from the hospital services (Sayers et al., 2016). Developing a sense of agency and autonomy is very important so that clients can believe in themselves and their abilities to experience mental health recovery without the constant care that is provided at the hospital, which is another key component of the Community Connections program.

Research also states that developing trust with the clients’ family members and understanding the family dynamic are pivotal for building rapport and in turn developing the ongoing support from the family for the client (Sayers et al., 2016). Effective communication between institutions, providers, clients, and their families is essential to the discharge planning process and overall recovery (Noseworthy et al., 2014). This understanding allows the practitioner to tailor strategies to individual needs based on familial supports, the family’s circumstances and their barriers, and ensure that family members understand the discharge plan and have the resources necessary to support the client. As stated previously, the more connected and supported clients feel, the more likely they are to experience higher life satisfaction, feelings of self-efficacy, and relatedness. It is important the clients know that even though they are
leaving the supports of the hospital, they have a support system at home and/or in the community, and that they know they have the skills to be able to live well on their own.

Furthermore, strategies that Noseworthy and colleagues (2014) found would improve the process of transition from agency to community included formal follow-up procedures to ensure that clients have successful transitions and provide additional support where needed, involve healthcare providers in evaluating and improving the process by keeping track of successful and not successful transitions (Noseworthy et al., 2016). By conducting this research, I will contribute to this body of knowledge by understanding meaningful aspects of the Community Connections program that may help clients have a successful transition from the hospital services into the community and experience important components of recovery.

**Value of Community Connectedness in Recovery**

Numerous researchers have identified that community integration should be the principle to guide mental health systems towards the recovery movement (Kaplan, Salzer, & Brusilovskiy, 2012; Jorge-Monteiro & Ornelas, 2016; Sayers et al., 2016). In a study conducted by Sayers et al., (2016) the researchers discovered two subthemes related to arranging community engagement to aid in recovery, which were enabling connections – community and family, and recovery and reconnecting with the community. The researchers state that making connections with the local community is essential for arranging support for clients (Sayers et al., 2016). Socialisation is viewed as an important tool in the transition from agency to recovery. Socialisation is defined as the activity of mixing socially with others (Oxford Dictionary, 2018) and can be a way to distract from the limitations that a client may be living with, by going out and doing regular everyday things such as going for a walk or getting coffee (Sayers et al.,
Social skills are important to develop as people reintegrate into the community, so that they can confidently access the resources they want and need both independently and in a group setting. Being connected to the community in a social context can help people feel more comfortable, supported, and efficacious during the recovery process.

In addition, Nelson and colleagues proposed that mental health systems should place their values on recovery, empowerment, community integration, the involvement of community members in the organization of services, and access to opportunities to participate and contribute to the community (Jorge-Monteiro & Ornelas, 2016), all of which are values in the Community Connections program. Another goal of community connectedness is the access to vocational opportunities, which can aid in mental health recovery. Individual placement and support approaches help people who have mental health concerns to obtain and maintain vocational opportunities, that can help them develop skills for the workplace as well as skills to aid in their recovery that contribute to overall well-being and community connectedness (Jorge-Monteiro & Ornelas, 2016). A study conducted by Mee, Sumson and Craik, (2004) suggested that certain attributes of occupation contributed to improving mental health and aiding in recovery, such as development of skills, coping with challenges, a sense of achievement, being creative and formulating a sense of self. As stated previously, being connected to the community and contributing to the community are important processes to achieve the goal of recovery and living well with mental illness, by developing a positive sense of place, social contexts, identity, and social connections (Yates et al., 2011), which is why the Community Connections program includes the development of these different processes to promote the achievement of sustainable recovery and connectedness in the community.
THE ROLE OF LEISURE AND THERAPEUTIC RECREATION IN RECOVERY

What is Leisure? How Does Leisure Aid in Mental Health Recovery?

The term leisure has many different definitions based on the context in which it is used. Leisure is a highly personal experience that can be defined as free time, an activity, or a state of mind. Hood and Carruthers (2013) define leisure experiences as “…engagements that are (1) pleasant in anticipation, experience, or recollection; (2) pursued for the intrinsic rewards inherent in the activity; (3) perceived as chosen in relative freedom; (4) expressive of essential aspects of the self; and (5) experienced in contrast to whatever is going on before or after, and thus involves a shift in perception or engagement” (p.122). Due to these positive qualities, leisure can be a powerful tool for individuals to utilize to help enhance positive emotion, experience a positive sense of self, and experience meaning in life.

There are many ways to think about leisure, and two of those ways is as engagement and disengagement. There are many forms of leisure that are effective in promoting engagement in one’s life and the community, such as expressive/creative, social, spiritual and cultural forms of leisure (Iwasaki et al., 2010). By being more engaged in the community, having a meaningful role within a leisure context, and experiencing feelings of mastery, positive emotions, and strengths, it may help people feel less stigma within themselves and within social groups, which will help with life satisfaction and psychosocial and emotional well-being (Hood & Carruthers, 2004). As research states, people who experience positive emotions through leisure are more likely to seek new and interesting experiences, while thinking more openly and creatively (Hood & Carruthers, 2004). The results of having success in these leisure experiences include
perceptions of competency, self-determination, and relatedness, all of which are important perceptions to help combat stress and stigma.

Leisure as disengagement can be just as valuable as leisure as engagement in the recovery process. Leisure as disengagement is a means to use leisure as a way to relax and unwind from the stressors and routines of daily life. This concept has been described by Kleiber as “the pause.” Disengaging from action and activity and deeply relaxing allows for a shift in perspective, allows for possibilities to arise, and supports personal integration, problem-solving, creativity, and reflection all while fully experiencing the present (Kleiber, 1999). By allowing ourselves to pause, it provides the psychological distance necessary to make judgments and applicable decisions about what to do in order to live the best life possible (Kleiber, 1999).

For those going through the process of recovery, it is important to take the time to disengage from the routines of their everyday lives, reflect on their experiences, consider what they want their future to look like, and experience the disengagement necessary to relax and take care of themselves and their emotional adjustment during this difficult process of change. Leisure can be a great way to disengage and de-stress, as leisure is described to be a freely chosen, enjoyable pursuit that utilizes strengths and interests in the experience. Leisure can be motivating, enjoyable, a strength-builder and skill-builder, a way to be expressive, relaxed, and sometimes a distraction from the difficulties of everyday life. With all these elements of leisure, it is important for individuals to understand what leisure is, how leisure can be beneficial to them, and what forms of leisure best suit their needs to experience the many benefits that leisure can provide.

Leisure comes in many forms, and as stated previously, the form of leisure is not as important as the meaning that a person assigns to the experience (Iwasaki et al., 2010). Leisure
can be a means to help people realize their potential, their strengths, talents, interests, explore their identity, relax, engage, become active and involved, experience positive emotion, resiliency, hope, and optimism. For a person who has a mental illness these experiences and emotions can be difficult to come by, which is why leisure can be an important tool to help a person experience these phenomena as a way to cope with everyday stressors and the negative effects of mental illnesses. To support this, research from Connell et al. (2014), states that activity had a positive effect on subjective and psychological well-being. Both leisure and work activity fostered a sense of belonging through social interaction and created feelings of self-worth, pride, and sense of achievement. The researchers state that the more meaningful, purposeful, and constructive the activity the better, rather than activities that merely fill time (Connell et al., 2014).

Outdoor recreation activities such as walking, sailing, and cycling are a form of leisure that has proved to include many positive benefits in its experiences. There are a number of valued psychosocial outcomes associated with outdoor recreation, including the development of skills, increased self-esteem and confidence, development of a positive self-identity and increased self-awareness, increased decision-making and communication skills, enjoyment of nature, and increased motivation (Frances, 2006). Other emotional benefits of outdoor recreation include the following: “…improvements in mood, distraction from mental health problems, enhanced coping mechanisms, increased ability to overcome challenges, developed emotional maturity, and increased self-acceptance” (Frances, 2006, p. 183). The benefits experienced in these activities have been found to be experienced in a variety of forms of leisure, the common experience being activities that initiate meaning, positive emotion, relatedness, and a sense of mastery or competency. The many benefits that can be experienced from meaningful leisure
activities can be pivotal during the recovery process to help people experience these important benefits in ways that are personally meaningful and enjoyable for clients.

In a study conducted by Lloyd et al. (2007), they found a significant association between leisure motivation and recovery by using the leisure motivation scale developed by Beard and Ragheb (1983) and the recovery assessment scale developed by Corrigan et al., (2004). The study showed that individuals who were motivated to engage in leisure identified with higher levels of components of recovery. Additionally, leisure motivation toward personal confidence and hope, and goal and success-oriented leisure had the strongest correlations with recovery (Lloyd et al., 2007). These findings suggest that by engaging in personally meaningful leisure, individuals may develop skills and motivation that can be useful tools to utilize during the recovery process and can continue to utilize these skills throughout the life span.

What is Therapeutic Recreation? How Does Therapeutic Recreation Aid in Mental Health Recovery?

There is no universal definition of therapeutic recreation, but there are a few underlying themes or philosophies of therapeutic recreation practice. Therapeutic recreation is a holistic, strengths-based approach that purposefully uses recreation and leisure interventions to bring about a change in people’s lives (Carter & Van Andel, 2011). Typically, the clientele for therapeutic recreation practice are those who live with disabilities and illnesses. Therapeutic recreation interventions help people maintain or improve their independence, health, functional abilities, quality of life and well-being. These changes can be social, emotional, cognitive, physical or spiritual. Using a strengths-based approach, therapeutic recreation helps people reach their goals and aspirations by focusing and utilising their strengths and personal resources to achieve those goals (Anderson & Heyne, 2012). Therapeutic recreation helps people find
meaning, hope, and competency in the recovery process. In mental health rehabilitation services, the integration of the recovery philosophy is an effective way to promote an engaged lifestyle in a holistic way, rather than a controlled medical way.

To connect leisure and therapeutic recreation to recovery, the recovery philosophy uses many of the core techniques of therapeutic recreation, such as a) helping someone form a vision of their own recovery, b) helping the person set goals, c) assisting the person in forming emotional connections, d) treating people with respect, e) empowering people, f) giving hope, g) teaching self-management, h) facilitating skills training and provide modeling in real settings, i) building social networks, and j) fostering community inclusion (Anderson & Heyne, 2012). By engaging in therapeutic recreation, clients may gain the resources and abilities needed to achieve these various components of recovery while using a strengths-based, person-centred approach to their recovery and the overall quality of their lives. The concepts and skills learned from therapeutic recreation practices can be transferred and utilized in all areas of life, which is why it is so important to implement with a mental health setting whose goal is to integrate and be included in the community. The Community Connections program is implemented by certified recreation therapists who use the recovery philosophy and core techniques of therapeutic recreation to provide effective services to their clients.

In the field of therapeutic recreation, the Leisure and Well-being Model (LWM) is a service delivery model that acts as a framework to provide strengths-based interventions to support clients of therapeutic recreation programs in the pursuit to live a full and meaningful life, despite limitations (Hood & Carruthers, 2016). “The model identifies leisure as an integral component of a life well lived and articulates the role of leisure in generating positive emotion, and developing the resources and strengths necessary for well-being” (Hood & Carruthers, 2016,
shift from agency to community

Researchers Hood and Carruthers (2016) examined the use of the LWM in a mental health context to see how the LWM could be used to contribute to clients’ recovery. Many of the components of the LWM were similar if not identical to many of the components of recovery, including engagement, hope, sense of self, sense of agency, autonomy, and self-determination. The Community Connections program that will be researched and explored for this project used the LWM as the guiding model of development to promote the growth of these components of recovery, specifically sense of self, sense of agency, autonomy, and engagement.

COMMUNITY CONNECTIONS PROGRAM

What is Community Connections?

Community Connections is a therapeutic recreation, outpatient program for individuals who have gone through the outpatient programs at the hospital and are ready for the next stage of their recovery – leaving the hospital services. The program has two main goals that the facilitators strive to help their clients achieve through their participation in the program: 1) To teach clients skills to be able to find leisure resources in the community, and 2) To teach clients skills to engage in leisure independently and with others in the community, in order to break down barriers to community integration. Each goal has various objectives, or steps to take in order to achieve these goals. For goal #1, it is stated that clients will complete assessments to identify strengths and leisure interests throughout the course of the program; Facilitators will teach clients the tools they need to find community resources and encourage clients to use these tools to facilitate their own leisure; and lastly, that clients will set goals for community integration to base their research, time, and energy into that set goal. For goal #2, it is stated to have clients engage in leisure activities every week of the program; clients will identify barriers
to community integration and how they can overcome barriers; and finally, that clients will be responsible for completing homework and all program tasks throughout the program. In addition to these two main goals, the Community Connections program aims to help clients develop a positive sense of self, sense of agency, and a sense of security within themselves and in the community so that they can continue to engage in the recovery process away from the hospital setting while growing and developing their own resources to live well with their mental illness.

The program consists of eight sessions that are one and a half hours each, once per week. The topics of the sessions are as follows: Introduction to Community Integration and Self-Awareness; Strengths and Leisure; Community Resources and Volunteering; Goal-Setting; Overcoming Barriers; Leisure Planning; Friendship Building and Enhancing Leisure Experiences; and Wrap Up and Review Leisure Plans. These session topics were developed based on the identified needs of the clients from the recreation therapists and the hospital, a literature review of important components of recovery and community integration. The sessions include informative handouts, worksheets, homework tasks, journals, assessments, post-session evaluations, activities, and discussions related to the session topic. Refer to table 1 for a brief explanation of each session.

**Table 1. Community Connections Program Outline**

<table>
<thead>
<tr>
<th>Session Title</th>
<th>Description</th>
<th>Components of Recovery</th>
</tr>
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<tbody>
<tr>
<td>Session One: Introduction to Community Connections and Self-Awareness</td>
<td>Introduce the topic of community integration, and the importance of self-awareness in the process of recovery, as well as complete pre-assessments to track progress from beginning to the end of the program.</td>
<td>Positive sense of self</td>
</tr>
<tr>
<td>Session One: Strengths and Leisure</td>
<td>Help clients discover their personal strengths and leisure interests as a way to aid in recovery and become engaged with the community.</td>
<td>Positive sense of self, sense of agency</td>
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<tr>
<td>Session Two: Community Resources and Volunteering</td>
<td>To raise awareness of resources that are available in the local community to practice their leisure pursuits in a community setting. Touch on the value of volunteering as a way to get involved and connected to the community.</td>
<td>Positive sense of place and security in the community, sense of agency</td>
</tr>
<tr>
<td>Session Three: Community Resources and Volunteering</td>
<td>Help clients understand the importance of setting goals for recovery and community integration, and start to develop personal goals for community integration through leisure.</td>
<td>Positive sense of agency</td>
</tr>
<tr>
<td>Session Five: Overcoming Barriers</td>
<td>Address the difficulties associated with overcoming barriers and limitations related to recovery with mental illness, and community integration.</td>
<td>Positive sense of self, sense of place and security in the community</td>
</tr>
<tr>
<td>Session Six: Leisure Planning</td>
<td>Identify the process of planning a leisure experience in the community (what, who, when, where, why, and how?)</td>
<td>Positive sense of agency</td>
</tr>
<tr>
<td>Session Seven: Friendship Building and Enhancing Leisure Experiences</td>
<td>Understanding ways to build and maintain friendships through leisure experiences, and applying savouring techniques to enhance the leisure experience, and further enjoy friendships.</td>
<td>Positive sense of self, sense of agency, and sense of security and place in the community</td>
</tr>
<tr>
<td>Session Eight: Wrap Up and Review of Leisure Plans</td>
<td>Review and reflect on concepts learnt throughout the program, have clients complete post-assessments to track progress from the beginning to end of the program, and facilitate future goal setting for continued leisure engagement in the community.</td>
<td>Positive sense of self, sense of agency, and sense of security and place in the community</td>
</tr>
</tbody>
</table>
CHAPTER THREE: METHODOLOGY

This chapter will explore the theoretical foundations and methodology used to guide this research project. This project used the method of a case study with a phenomenological lens to answer the main research question (1) What are the clients’ experiences of the Community Connections program? The sub-questions include, (a) How does the Community Connections program effect clients’ recovery process? (b) How does the Community Connections program support skill development for community integration? (c) How does the Community Connections program shift clients’ perspectives about engaging in leisure in the community? This chapter will give a detailed explanation of the research process for this project by explaining the participant recruitment and background, the data collection methods and the data analysis, followed by descriptions of trustworthiness and ethical considerations to ensure this project is reliable, valid, and safe for participants, the organization, and the researcher.

THEORETICAL FOUNDATIONS

Epistemology

Epistemology is the theory of knowledge and how we can differentiate between what is true and what is false (Hildegard, 1988). Common questions asked in epistemology include, “(1) what can we know? (2) how can we know it? (3) why do we know some things but not others? and (4) how do we acquire knowledge?” (Cline, 2017, p. 1). Modern epistemology generally involves a debate between rationalism and empiricism (Cline, 2017). Rationalism is defined as knowledge gained through reasoning and logic, without any direct interaction with the phenomenon under study (Cline 2017). Empiricism, on the other hand, is defined as knowledge gained through direct experience with a phenomenon (Cline, 2017), which is the epistemological
lens that was used for this study. There are a few ways to conduct a study within an empirical epistemology, however the approach that best suited the needs for this research project was constructivism.

Constructivism suggests that “truth” or “reality” is socially constructed and that in every situation there are multiple realities (Schwandt, 1994). In taking a constructivist view, the aim was to understand people’s lived experiences from the perspective of individuals who live that experience (Schwandt, 1994). The philosophy of constructivism believes that people construct meaning through social actions and interactions, and that there are multiple realities, all of which are socially and personally constructed. In other words, someone who takes a constructivist view believes that in order to understand meaning in the world, one must interpret it by clarifying how meanings are embodied through social interactions and interactions with the world (Schwandt, 1994); one must examine and understand each individuals’ construction of their experience in a particular phenomenon. I believe that individuals create meaning through their interactions with the world, and that this is applicable to a mental health recovery lens, meaning that people develop their attitudes towards mental health recovery through their interactions with the world around them. This study was embedded in a constructivist epistemology to support my case study with a phenomenological lens.

**Theoretical Framework: Phenomenology**

Phenomenology is the study of people’s lived experiences with a focus on understanding the ways in which they interpret those experiences to create meaning (Van Manen, 2014). Therefore, a phenomenological research study aims to understand how people construct meaning towards a certain phenomenon or experience in order to understand the experience as it is
experienced from a subjective or first-person point of view (Van Manen, 2014). In this research study, this first-person point of view of people’s experiences in the Community Connections program and their experience of mental health recovery was the main focus of the study. By gaining an understanding of their lived experiences and exploring the different impacts that people have encountered that have been both adaptive and non-adaptive in their lives, my hope was that this would give people and mental health practitioners insight into what is important and helpful for clients who are going through the process of recovery. More specifically, if I could gain insight into clients’ experiences of the Community Connections program, direct changes and approaches could be taken to improve the program based on clients’ needs to help them achieve the objectives that are in place for them to achieve recovery and wellness.

Phenomenology was developed by Edmund Husserl at the start of the twentieth century. Husserl studied mathematics and psychology, and taught at Göttingen University where he developed and advanced the principles of phenomenology (Ungvarsky, 2017). The books in which he introduces the ideas of phenomenology, called Logical Investigations present the idea of phenomenology as a form of transcendental idealism. “Immanuel Kant defined transcendental idealism as the viewpoint that differences or distinctions exist between how humans perceive objects and how those objects are in reality” (Ungvarsky, 2017, p. 1).

Given that leisure and mental health recovery are both considered to be socially and personally constructed, a constructivist, phenomenological approach is appropriate and relevant. Research supports the use of phenomenology in psychology and healthcare, stating that phenomenological approaches can be especially important to help determine how an individual feels about a situation instead of assuming that each patient perceives the same symptoms, losses or gains in the same way due to its individualistic nature (Ungvarsky, 2017). Additionally,
Ungvarsky (2017) states that physicians can better customize care plans when they understand how clients perceive their condition by using various methods as opposed to using a “one plan fits all” approach. For the reasons listed above, phenomenology is an appropriate theoretical lens to use as the framework for this research project.

**METHODOLOGY**

**Case Study**

As defined by Merriam and Tisdell, (2016) “a case study is an in-depth description and analysis of a bounded system” (p. 37). As a research process, a case study is defined as an inquiry that investigates a phenomenon (the case) within its real-life context (Merriam & Tisdell, 2016). For this research study, I investigated participant experiences of a specific program intervention (the Community Connections program is the case) as related to mental health recovery. Considering that I examined the phenomenon of mental health recovery within one program as well as examined clients’ experiences as participants in the program that had a set beginning and end and limited number of people who could be interviewed and observed, these boundaries constituted the parameters of the case study (Merriam & Tisdell, 2016). I also analyzed the components of the program, including the session topics, completion of homework tasks such as journals, and observed the participants’ behaviour while in the program to gain insight into their level of engagement and confidence in their abilities to implement these behavioural changes learned in the program in their everyday lives.

Collecting evaluative data to gain insight into the success of the program, helped form a basis for future decision-making regarding the hospital and its mental health programs and services (Merriam & Tisdell, 2016). I collected evaluative data by obtaining descriptive
information acquired during the implementation of the eight sessions (i.e., attainment of session objectives, social validation, completion of homework tasks and worksheets). After the program was complete, I conducted individual interviews where I asked questions about the success of the program and the clients’ perceptions about the program, all of which will be explained further in this chapter. In conclusion, my research study used the method of a case study with a phenomenological lens.

COMMUNITY CONNECTIONS AND STUDY SITE

The Community Connections program is a therapeutic recreation intervention that is intended for clients who are near the end of their rehabilitation services at the hospital. The aim of the program is to prepare individuals to integrate into the community through the context of leisure. There are two main goals for the clients to achieve during their time in the program: 1) To teach clients skills to be able to find leisure resources in the community, and 2) To teach clients skills to engage in leisure independently and with others in the community, in order to break down barriers to community integration.

With these goals in mind, the topics for the eight sessions were developed to help clients achieve those goals and gain confidence in their ability to integrate into the community and continue their process of recovery. The eight topic sessions are as follows: Introduction to Community Integration and Self-Awareness; Strengths and Leisure; Community Resources and Volunteering; Goal-Setting; Overcoming Barriers; Leisure Planning; Friendship Building and Enhancing Leisure Experiences; and Wrap Up and Review Leisure Plans. The sessions include informative handouts, worksheets, homework tasks, journals, assessments, post-session evaluations, activities, and discussions related to the session topic.
The recreation therapy team at the hospital who work in the Outpatient Mental Health Unit lead this program. There are always two certified recreation therapists leading this program that is an hour and a half in length, once a week, for a duration of eight weeks. Since this program is intended for clients who are near the end of their rehabilitation services at the hospital, the clients are referred to this program from the staff members in the interdisciplinary team (recreation therapists, nurses, social workers, psychiatrists and psychologists) based on their readiness to integrate back into the community and continue their recovery from home and community resources.

When clients are referred to the program, they may choose whether they would like to be put on the wait list for that program. If clients accept, they are placed on a wait list based on when they were referred to the program. The receptionists in the unit call clients who are at the top of the wait list to inform them of the program information and ask them whether they would like to participate in the program. The clients on the list are called until all spots are full in the program. Based on the nature of this program and the desire to keep the program close and intimate so that each client can have the attention and time they need with the group leaders, there are typically 8-15 participants in this program. This is based on how many people accept to participate in the program from those that were on the wait list. Participants have various types of mental illnesses, ranging from mild to moderate, including mood disorders, anxiety disorders, personality disorders, etc.

PARTICIPANTS

Participant Background
Participants who were recruited for this study came from a referral list made by the interdisciplinary team in the Outpatient Mental Health Unit based on their readiness to be involved in the program, making this a convenience sample. Participants hail from a region in Southern Ontario, who are adults, 18 years of age or older due to the policies of the adult mental health services at the hospital. There are no limitations other than age for who can receive services from the hospital.

**Participant Recruitment**

With the hospital’s program system, clients are placed on a waiting list for the program when they are referred to the program. When the program is scheduled to start, clients are called to be told the date, time, and location of the program and asked if they would still like to participate in the program. The recreation therapist who facilitated this program made these phone calls and was given a phone script to invite and inform the clients about the research study. The script outlined the purpose of the research, what the research entailed, and my contact information so that the potential participants could contact me for more information regarding the research project (see appendix A for the phone script). In order to ensure that there would be enough research participants to effectively complete this study, the recreation therapists kept track of how many people accepted and declined to be part of the study. The minimum number of participants for this study was four people and the maximum was eight, so they continued to invite people to participate in the program until the maximum number of participants accepted to be in the research study. In order to protect study participants’ privacy, the recreation therapists decided to facilitate two groups for the Community Connections program; one group consisted of only research study participants and the other group consisted of clients who did not want to be a part of the research study. This way, study participants’ identities were protected and clients
who did not want to be in the research study could receive the services they wanted without feeling like they were being observed or evaluated during the program. For the research participants, they were told they would receive more information about the research on the day of the focus group before the focus group began so they could be informed about the full details of the research, their rights as participants, and the ability to withdraw from the study at any time.

**DATA COLLECTION METHODS**

There were four different data collection methods used in this study to effectively answer the following research question and sub-questions: (1) What are the clients’ experiences of the Community Connections program? (a) How does the Community Connections program effect clients’ recovery process? (b) How does the Community Connections program support skill development for community integration? (c) How does the Community Connections program shift clients’ perspectives about engaging in leisure in the community?

The first data collection method was a focus group conducted one week before the Community Connections program started with all participants of the research study. This was done in order to gain insight about their experiences with mental health recovery throughout their time at the hospital and throughout their lives. The second and third data collection methods were social validation and participant observation which occurred throughout the duration of the eight-week program with all research participants. This was done to collect descriptive data and evaluative data about the success of the program based on whether or not the goal of the session was met, the homework from the week before was completed, to track people’s engagement with the session content, and gain any feedback about what people liked or did not like about the
sessions. This information helped inform the individual interviews that were conducted one to three weeks after the program had ended. The purpose of the interviews was to gain a deeper understanding of the participants’ experiences with the program to see how the program may or may not have contributed to their process of recovery and understand what they learned from the program or thought was missing from the program that could have helped them with their recovery. The four data collection methods will be explained in further detail in the sections to follow.

Table 2 shows the chart that was used to track these various data collection methods throughout the research project.

**Table 2. Data Collection Methods**

<table>
<thead>
<tr>
<th>1. <strong>Focus Group</strong> – all participants</th>
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<tbody>
<tr>
<td>2. <strong>Program Data Collection</strong> – all participants</td>
</tr>
<tr>
<td>Session 1</td>
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<td>Session 2</td>
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<td>Session 3</td>
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<td>Session 4</td>
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<td>Session 5</td>
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</table>
Session 6

Session 7

Session 8

**3. Individual Interviews** – four selected participants

**Focus Group**

I conducted a focus group one week before the Community Connections program started to explore the participants’ perceptions of the various components of the Community Connections program and the ways in which these components intersect for the participants with recovery and living well. The purpose of conducting focus groups is to understand how people feel or think about a particular topic (Krueger & Casey, 2014). I facilitated this focus group before the program started with all the research participants to explore their conceptions of their experiences in outpatient mental health programs, their feelings about ending their programming at the hospital and entering a community setting, their perceptions about mental health recovery, and their experiences of recovery with mental illness.

Focus groups are beneficial because they allow researchers to understand how a phenomenon is perceived by members of the group in which that phenomenon exists (Krueger & Casey, 2014). Focus groups are intended to promote self-disclosure among participants, as participants naturally influence each other by their interactions in the group (Krueger & Casey, 2014). Focus groups work best when participants feel relaxed, respected, relatable, and safe to
share their opinions without being judged. Focus groups are typically composed of 5 to 12 people, so that it is small enough for everyone to have an opportunity to share their insights, but large enough to provide diverse responses (Krueger & Casey, 2014). Researchers typically plan to conduct focus groups for an hour and a half to two hours, depending on the size of the group, the age of the group, and the topic being discussed (Jamshed, 2014). Although the focus group may not last as long as two hours it is important for the participants to plan accordingly (Copely Focus Centers, 2012).

The focus group was held prior to the beginning of the 8-week program to gain an understanding of the participants’ experience of recovery before they started the program and again after they completed the program. To collect data post-intervention, I used individual semi-structured interviews, which will be explained in detail later in this chapter. Additionally, the focus group was used to gain the participants’ perspectives of the outpatient programs at the hospital, which lead to discussions about various aspects of mental health recovery such as barriers people have encountered, resources that have helped people, the effects of stigma, and living with various mental illnesses. The focus group questions were used to discuss the participants’ experience, knowledge, understanding, and application of recovery at the beginning of the program. The questions that were used for the focus group are outlined in Appendix B.

Social Validation

At the end of each session of the program, as part of the ongoing session evaluation, participants were asked to complete a written evaluation to indicate their level of understanding and attitudes toward the content given in the session and to ensure that the goals of the session were met. This type of assessment is referred to as social validation. Research supports the use of
social validation measures to assess the participants’ perceptions about the rehabilitation goals and outcomes (Foster & Mash, 1999). The three components of social validity for rehabilitation are rehabilitation goals, procedures, and outcomes (Foster & Mash, 1999). I have modified the social validation questions for the Community Connections program based on the three components listed prior: (1) how important is this topic?; (2) how much do you feel your awareness or skills related to the topic has changed/how much have you improved?; and (3) how confident are you that you can use this information and these skills in your everyday life? Questions were answered using a 5-point Likert scale. The data that was collected in this portion is considered descriptive and was used as a prompt in the final interview.

In addition to these questions, there was also room to write comments if clients wished to elaborate on their answers or give further feedback. This was a helpful way to gain the participants’ insight about the effectiveness and meaning of the program content related to their experience of the program and the effect it had on their process of recovery (Foster & Mash, 1999). The social validation assessments used for the eight sessions are listed in Appendix C, D, E, F, G, H, I, and J.

**Participant Observation**

In addition, observations were used to track participant engagement in the program in order to explore clients’ responses to and lived experiences of the various program components (see Observation Tracking Form, Appendix K). Observations are accounted for by the researcher as the experience is occurring to represent data that comes firsthand from the participants in a natural context (Atlas.ti, 2018). Observations serve the purpose of representing data that comes from a firsthand account with the phenomena as it is happening without
intervention from the researcher rather than a second-hand account of the experience that would be obtained in an interview, as an example (Merriam & Tisdell, 2016). Observations are an important method of data collection for case studies as it makes it possible to record behaviour as it is happening rather than trying to recall things that have happened in the past, making it a more authentic account of the experience (Atlas.ti, 2018; Merriam & Tisdell, 2016). Observations can be helpful as an outsider, as the researcher will notice things that may have become routine to the participants, and things that may give context into understanding the experience (Merriam & Tisdell, 2016). Observations can be a good way to triangulate findings when used in conjunction with interviews and documents to substantiate the findings. Additionally, when an observer uses their knowledge and expertise to interpret the experience in addition to data gathered from interviews it allows them to have various methods to interpret and understand the data deeper than just one account from interviews or documents.

Throughout the program there are various approaches used to interact with clients, such as discussion questions, brainstorming ideas, assessments, activities in groups and independent worksheets. These activities can include discussions and worksheets, as well as homework assignments such as journal entries to encourage active participation and practice of the concepts discussed at home in their everyday lives. The completion and engagement of this work was observed throughout the program to contribute to the descriptive results of the data collected from the social validation and participant observation.

During the hour and a half long program, I observed the participants’ behaviour and reactions to the activities, discussions, and homework take-up. I observed to see if and how engaged the participants were in the activities by watching to see if they were physically participating by contributing to the conversation, asking questions, completing the worksheets or
taking notes. I observed their emotional responses to activities and discussions such as seeing if they were excited, happy, reflective, self-actualizing, upset, discouraged, confused, etc. I observed to see if after completing tasks at home, if they understood and applied the lessons from the week before, and to see which tasks worked well and which ones did not work well to ensure that these concepts were meaningful, understandable, and manageable. I also kept track of progress made for the clients throughout the program to see if their perspectives changed, to see if they were following along with the program and understanding, appreciating, and applying the concepts they were learning in their everyday lives based on their stories and worksheets. At the end of each program, the program facilitator would ask debriefing questions and conduct written evaluations to see if the clients achieved the objective of each program, based on the goals and objectives pre-determined in the program outline.

Throughout these observations there were four main categories that I aimed to observe during each program. The categories were moments of actualization, (or a-ha moments), moments of confusion, moments of full engagement, and moments of boredom or disconnect. The chart shown in Appendix K was used to organize the notes made from the participant observations using these four categories with subsections to indicate what the topic or activity was, and what happened to indicate that it was important to note for that specific category. For each session I had separate charts for each person to keep their information organized. By making note of these moments throughout the program, it gave me further insight into the attitudes, understanding, and experience of the program from the perspective of the participants, which may be helpful while further developing and enhancing the program, and programs like it to ensure that clients have an optimally helpful and enjoyable experience in the program. The
data collected in this portion was also considered descriptive and was used as a prompt in the final interview.

**Interviews**

I also used individual semi-structured interviews after the program was completed with participants as a means to further discover the participants’ perceptions of the Community Connections program, their thoughts about the various components of recovery, including community connectedness, and to see how these perceptions may be different from the general responses from the focus group questions that had similar questions to the interviews.

Individual interviews are particularly helpful in order to find out things about people that researchers cannot directly observe, such as their feelings, thoughts, intentions, and the meanings they attach to what goes on in the world; it allows the researcher to enter into the participants’ perspective (Patton, 2015). For semi-structured interviews, the interview is a mix of more and less structured questions that can be used flexibly, in no pre-determined order. Usually, specific information is desired from all respondents, but the ways in which the interviewer acquires that information does not have to be the exact same from one interview to the next (Merriam & Tisdell, 2016). As Merriam and Tisdell (2016) state, this allows the researcher to respond to the interviewee based on their worldview and new ideas on the topic. Interviews are an effective way to acquire specific information from the participants and gives the interviewees a chance to tell their life world stories in an intimate, relaxed setting, making it an appropriate and necessary form of data collection for the phenomenological method (Merriam & Tisdell, 2016; Van Manen, 2014). Researchers suggest that semi-structured interviews generally cover the duration of 30 minutes to more than an hour (Jamshed, 2014). The interviews conducted for this study all
lasted between an hour and an hour and a half. See Appendix L for the individual interview guide.

In my original research proposal, I stated that interview candidates would be purposefully selected based on their engagement in the program, because the expected number of participants was between four to right considering the usual group size for this program. Due to the new mental health system at the hospital and given the timing of the research, there were only six people originally recruited to the program and ultimately there were three participants who completed the program and participated in the research. For this reason, I chose to interview all three of the participants who completed the program.

The interview questions were developed using the research questions, components of recovery, and components of the program as a guide to develop well-rounded questions. Additionally, sorting cards were made based on the topics from each session and I asked participants to rate the importance of the learning outcomes to their recovery. The interview questions are outlined in Appendix L.

DATA ANALYSIS

All of the information for the data analysis will be organized in groups based on the method of data collection (focus groups, participant observation, social validation and individual interviews), making the data easily retrievable (Yin, 2014). Throughout the data collection process, the different data collected was organized by the method of data collection used, and pre-analyzed by reviewing the data and making notes as the events happened to ensure that all fieldnotes were included in the in-depth analysis. A case study record was made to pull all the information together that was used for the in-depth analysis (Yin, 2014). To analyze the data, I
used the strategy of relying on the theoretical propositions that this case study was based on, which was reflected in my research questions, the review of the literature and theoretical foundations for the methodology, and looking for patterns in the data (Stake, 1995; Yin, 2009).

The following strategy was used as the foundation for the data analysis, as suggested by Saldana (2009):

1. organizing and preparing the data for analysis,
2. coding and describing the data,
3. classifying and categorizing themes,
4. connecting and interrelating the data, and
5. interpreting and making conclusions about the data.

The first data that was collected was from the focus group. The focus group was audio recorded, so I transcribed the data by writing out word for word what was said in the focus group and who said it. After the data was transcribed, I started the process of coding. In qualitative data, a code is often a word or short phrase that symbolizes a summative, prominent, essence-capturing attribute for a portion of data (Saldana, 2009). In simple terms, a code represents the content and essence of the data collected. I wrote codes in the margins of the pages to symbolize the essence of the portion of the data for the entire focus group script. While coding, I referred to my field notes to see what stood out to me during the focus group interviews that could inform the coding process. In addition to themes that emerge from the data, I used a coding list as suggested by Yin (2009), to help inform the coding process. The coding list was based on the research questions, the components of recovery, the barriers to recovery and discharge, and the session topics: Hope and optimism, meaning making, positive identity, empowerment,
connectedness, shift in attitudes or perspective of mental health recovery, hospital as a safe place, experience in rehabilitative services, community integration, self-awareness, strengths, leisure, community resources, goal-setting, overcoming barriers, leisure planning, friendship building, and savouring leisure. After reading the transcript and getting immersed in the data, I was able to eliminate some of the codes from the list that did not pertain to the questions or the content of the focus group to make the coding more specific to the data. The process of coding continued until the data became saturated and I could not find any more codes within the data upon analyzing the script several times.

When coding the participant observation notes, I simply coded using the categories that were used to track my observations, which were “a-ha” moments, full engagement, moments of boredom, and moments of confusion with consideration of the session topics. Similar to the social validation, the participant observation notes were used for descriptive results to support and guide the individual interviews and the overall data analysis, so this analysis was not as in-depth as the focus group and the individual interviews.

For the social validation measures, these scores were used as descriptive results to show the progress and thoughts of each participant about the session topics as they happened. I kept track of what participants indicated as important, areas that they have improved in, and their level of confidence to use the skills learned in the session as these are the three questions used for the social validation written assessment. I created charts for each participant to show their scores for the social validation questions for each session to indicate the sessions that seemed to be most effective and ineffective for them, along with a document to keep track of their written comments for the social validation measure. By keeping track of these documents throughout the program based on the session topic, it helped give me insight into the thoughts and feelings of
the participants as the program was occurring as opposed to asking the participants to recount how they may have felt during the program upon completion of the 8 week program. By seeing levels of importance, improvement and confidence for each participant and the collective group, this allowed me to tailor the interviews to the participants based on what was important and not important to them to gain more insight into the reason behind their responses.

The process of transcription and coding that was used for the focus group also occurred for the individual interviews that took place one week after the program concluded and were also audio recorded. I kept the interviews and analyzing separate by participant as recommended by Saldana (2009) who states that when coding contrasting data it may be helpful to code one participant’s data first then progress to the second participant to keep it organized. I listened and transcribed the data from the interviews, then read and coded the transcript to note data that stood out to me based on the previous codes from the focus group transcript, the notes from the social validation and participant observation, and any new themes that emerged from the data analysis. When coding the interviews, I used the following coding schemes (the session topics) in addition to new themes that emerged to indicate important data: Self-awareness, strengths, leisure, community resources, goal-setting, overcoming barriers, leisure planning, friendship building, savouring leisure with the overall themes of mental health recovery and community integration. I continued to listen to the interviews and reviewed the transcribed interview script until the common themes emerged and re-emerged from the data, indicating that the data had been analyzed to its maximum capacity.

When all data was collected and analyzed, I put all the major themes together and looked for conceptual groupings of the themes, overlapping data, similarities, and differences between the responses from the case study record to answer my research questions. From there, I wrote a
final case study report with the organized and edited information, noting the major themes and categories from the data analysis to answer my research questions (Merriam & Tisdell, 2016).

**Trustworthiness**

Qualitative research is not designed to capture an objective “truth” or “reality”, however, even though the goal of qualitative research is to discover subjective meanings of experience, there are still various strategies that can be used to ensure that the research is credible. One of the most common forms of achieving internal validity is through triangulation. By using multiple methods and multiple methods of data collection this allows the researcher to confirm the themes that emerge by checking multiple methods to find the same theme (Merriam & Tisdell, 2016).

For an example related to this project, what is said in an interview can be checked with what was written in an assessment or observed during a session of the program. To further the experience of internal validity, I continually consulted with my research supervisor to conduct expert debriefing (otherwise known as peer debriefing), to ensure that the findings that emerged from the data were credible. As Patton (2015) explains, “triangulation, in whatever form, increases credibility and quality by countering the concern (or accusation) that a study’s findings are simply an artifact of a single method, a single source, or a single investigator’s blinders” (p. 674).

Another strategy for trustworthiness is member checks, otherwise known as respondent validation. The purpose of member checks is to receive feedback about the initial emerging data from observations and interviews to make sure that the participants agree with the findings that have emerged. This is an important strategy to ensure that the researcher has not misinterpreted that data that they have collected. When conducting member checks for this study, with their
consent, I sent an email to the participants with a document that outlined the data that I had collected about them and asked to identify which aspects of the analysis were true and which ones needed some clarification and fine tuning so that it can be true and representative of their experience with the program. The focus group will be conducted at the beginning of the eight-week program, observations will be made throughout the program, and written components were included as well. I did the member check about one month after they had completed their final interviews with me to ensure that when I contacted them I had a full analysis of the data that was collected throughout the process. Upon completing the member check and getting their feedback, I had a better understanding of their perspectives and attitudes toward the program and their experience of recovery.

Related to the integrity of the researcher is referred to as the researcher’s position or reflexivity, which is how the researcher affects and it affected by the research process (Merriam & Tisdell, 2016). Researchers need to state their biases, dispositions, and assumptions regarding the research to be undertaken so that the reader can have a better understanding of how the researcher interpreted the data and came to the conclusions that they did (Merriam & Tisdell, 2016). For me, I have stated my potential bias as one of the co-contributors of the Community Connections program. However, I state that I wanted to see which parts of the program were going well and which ones were not so that I could give informed suggestions to help improve the program.

The notions of transferability and extrapolation allow qualitative researchers and the readers to understand how the findings can be applied elsewhere in similar situations (Merriam & Tisdell, 2016). In this case, the generalizations are thought of more as working hypotheses that consider the conditions in a specific context to apply the findings to similar situations. Similarly,
extrapolations are speculations on the likely applicability of findings to other situations under similar conditions. Merriam and Tisdell (2016) state that “extrapolations are logical, thoughtful, case derived, and problem oriented rather than statistical and probabilistic” (p. 255).

To improve the possibility of data being generalizable or transferable, the use of rich, thick description can allow for a more in-depth description of the setting and participants of the study as well as a detailed description of the findings with quotes from participant interviews, field notes, and documents as adequate evidence to show the authenticity and raw data from the study. To conclude, an important part of ensuring the credibility of a study is that the researcher is trustworthy in conducting the study in as ethical a manner as possible (Merriam & Tisdell, 2016).

**Ethical Considerations**

When working with a vulnerable population there are various ethical considerations that must be followed throughout the research process. Before the research began, the project proposal was reviewed and approved by Brock University’s Social Science Ethics Board, as well as the Hospital’s ethics board which is run through the Hamilton Integrated Health Sciences Ethics Board to ensure that ethical considerations were made for the researcher and the participants in the study.

As stated prior, when the program at the hospital was scheduled, clients were contacted by telephone to be told the date, time, and location for the program. During this telephone call, clients were informed about the opportunity to participate in the research project and given a brief introduction about the research purpose, tasks, and contact information to receive more information about the research parameters. On the first day of the program, before the focus
group began and all potential participants were present, I further explained the purpose of the study, a step by step description of the research process, the risks and benefits involved in the study, the extent of confidentiality, how the data will be published and stored, the use of recording devices, a statement of voluntary participation and the ability to indicate whether or not they would like to participate in the research. I stated that if a client chooses to not participate or to withdraw from the study they will not receive any form of penalty or experience bias while continuing their care in the program. After participants were informed and able to ask any questions they had, the participants signed the informed consent form, indicating that they agreed and understood their rights and what they were being asked to do as research participants. The form was also signed by a witness, which was the program facilitator and a certified staff member at the hospital, in addition to my signature as the researcher.

For the confidentiality of participants, all participants names were confidential as they chose pseudo-names to be used in the recorded and published data. The list of pseudo-names with participants’ actual names was listed in a protected document on the researcher’s private computer. Confidentiality is expected and enforced in the groups at the hospital, which all participants are aware of as previous participants in other programs. However, confidentiality was enforced through verbal reminders that all information shared in programs must stay within the people in the program, and not repeated outside of the program.

Additionally, participants were informed of the nature of the study and what information was being collected throughout the groups. The use of a tape recorder was necessary to transcribe the interviews and focus group that was held at the beginning and end of the program, so participants were informed of this before the focus group and each of the interviews began. Also, if participants wished to not have their data collected at any time throughout the study they
were able to inform the researcher of their wish to withhold the information from the research study, which did not occur at any time during this project.

There is no external funding for this research project.

There is potential conflict of interest in this research study as I, the researcher, was a co-developer of the program being studied. While I have heard informal feedback that the program has been successful and helpful in people’s process of recovery, I know that there are parts of the program that could be improved. The nature of this research study is to understand people’s experience of personal recovery and using this program to see how the program may be contributing to their experience of recovery. I not only want to know which aspects of the program are working well for people, I also want to know which aspects of the program are not working well for people so that similar mistakes can be avoided and fixed in the future.

Additionally, I used the method of expert debriefing along with the other strategies for trustworthiness stated previously (triangulation, member checks, my reflexivity, and ethical considerations) to ensure my dependability throughout this study. My research supervisor and graduate studies advisor, Dr. Colleen Hood is an objective, third party member who continually reviewed my documents and reflected upon my observations to ensure that I remained open-minded and unbiased during the collection, analysis, and writing process.
CHAPTER FOUR: RESULTS

Results

Based on the conclusions from the data analysis, I have summarized the findings and major themes from this research project. While the clients highlighted some important parts of the program, they also identified some areas for improvement based on their experience of the program, how their involvement in the program impacted their recovery, how the program shifted their ideas about engaging in leisure in the community, and the skill development related to community integration.

PARTICIPANT DESCRIPTIONS

All participants who were invited to this study met the inclusion criteria of being an adult, 18 years of age or older, who has a diagnosis of a mental illness or multiple diagnoses, who are patients in the outpatient mental health program at the hospital. In total, five participants started the study, three completed it.

Samantha is a 36-year-old, Caucasian woman. She works in the education field and was unable to work, but has recently gained employment in the education field as well as an agriculture job with her municipality. She has taught in different countries around the world, including England, Italy, South Korea and Czech Republic! Samantha is a very kind-hearted person who is passionate about teaching children and showed great strength in her organization skills and independence. Throughout the program, Samantha expressed interest in engaging with singing, agriculture and gardening, volunteering in the community with kids or seniors, and scrapbooking.
Ariel is a 39-year-old, Caucasian woman. She is a mother of two and a wife. Ariel works in healthcare and is currently unable to work. Ariel is a very empathetic person; she was always offering advice and encouragement to the other participants in the program and would often have a positive outlook for various situations that could be seen as negative. Throughout the program Ariel expressed interest in listening to music and dancing, going for walks and hikes, playing games with her kids, and cleaning her home.

Elizabeth is a 53-year-old, Caucasian woman. She is a proud mother of three, a wife of many years, a dog mom, and works in the financial service industry. Elizabeth is a very generous person, who is passionate about giving to others, whether it was through her baking or spreading acts of kindness stones, she was always supportive in the group. Throughout the program, Elizabeth expressed interest in volunteering, going for walks, baking, and arts and crafts.

There were two participants who chose to withdraw from the program and therefore the research study. There was one person who agreed to participate in the research study when contacted for the initial invitation, but did not come to the focus group or the sessions of the program and therefore was never a research participant. The first participant, Eva, participated in the focus group but did not come to any of the classes for the program. Upon conducting the exit interview via email, she stated that she did not feel prepared to be in this type of exit program. The second participant, Norman, participated in three sessions of the eight-week program and withdrew after the third session. During his exit interview via telephone, he stated that he realized that he got away from his initial intentions for coming to the hospital for programs, which was for pain management. Upon this realization, he was discharged from the outpatient mental health programs at the hospital. Both participants gave their consent to keep their data in the study.
FOCUS GROUP

To analyze the focus group, I was focused on a few main topics that were related to my research questions; the clients’ experience of recovery, the clients’ experiences in other programs at the hospital, and their ideas about engaging in leisure in the community. The focus group was an hour and a half long, where most of the time was spent talking about the clients’ experiences of recovery and their experiences in the mental health services at the hospital. Based on the topics of conversation and the main topics I was focused on, I was able to use my coding list to guide the analysis, and there were also different themes that emerged during the analysis. Below, I will discuss some of the common themes and topics that emerged from the focus group data.

The focus group was conducted in a meeting room at the hospital, one week before the program officially started. The facilitator, the student intern who would be the assistant facilitator, and I met with the clients to inform them of the research process and give them the consent forms to sign before the focus group began. When all forms were signed and questions were answered, the facilitators left the room. We formed a closer circle with the chairs and moved the desks to the outside of the room to create a more welcoming and inclusive environment for everyone. There were five clients and myself in the circle.

Experience with Mental Health Services

Theme of Tension

Throughout the focus group and upon analyzing the data it was clear that there was some tension between the responses and expectations versus people’s reality. On one end of the spectrum, some participants spoke about the positive experiences they have had at the hospital, whereas others had some negative experiences to share. While some people stated that they
enjoyed the programs at the hospital because they learned a lot and were supported from other clients in their groups and the facilitators, others had completely opposite experiences where they felt like they had not learned a lot and did not feel like they were making social connections with the people in the groups. Even the same people who said that they had made friends at the hospital and felt safe and confident at the hospital also said that they felt there was a lack of social connection in the groups. Below are some direct quotes from the focus group to support these claims:

“I very much appreciate even having the opportunity to take the classes that I have, because they have helped me tremendously...” – Ariel

“When you have like 30 people in here and you’re trying to get help with whatever is being thrown at you, it’s not beneficial.” – Ariel

“I just felt like there could have been a lot more connection with the people you’re spending the next 6 to 10 weeks with. We’ve had people come in and go out but we don’t know anything about each other. And when you’re dealing with anxiety and depression, making a connection to other people is so important and not existent for a lot of us.” – Samantha

“I met a lot of friends, and really good friends that you can talk to and relate to. Where we go out for coffee, or our kids hang out.” – Ariel

In reference to the content of the programs there also seemed to be a tension between the expectations of the clients versus the expectations of the facilitators. Various clients stated that there was a disconnect between the content and tasks for the programs and their current life situations. The clients felt like the programs were generic, so that the facilitators could present
the information to anyone and hopefully reach each person in the room in one way or another. The clients said that sometimes they couldn’t relate to the content which made it less meaningful. The times when they could relate to something and were told about a useful skill and asked to practice that skill at home or in their everyday lives, they often were not able to utilize those skills because the situation where the skill could be used did not occur, or they weren’t confident in their ability to actually use the skill correctly or effectively. And since there are new skills and content to learn, they move on from the skills from the previous week without really learning or practicing those later skills. Below are some quotes from the clients regarding this matter:

“And then you have one week to use that skill, which you may or may not need in the situations of your life and then you move on. And you’re so quick to fast track through the program so that all the information is given but it’s just overwhelming.” – Samantha

“I understand the purpose of the program but it’s not individually tailored. We all experience mental illness in a different way, and it’s like, well this is what’s available, you either fit into this or you don’t.” – Samantha

These examples show how there is a disconnect between what the facilitators feel like is important for the programs versus what the clients think is important for the programs, which can create a divide in the relationship between the clients and facilitators, which may affect the effectiveness of the programs at the hospital.

Clients also experienced tension between the access to community resources and mental health services that were external from the hospital. The topic of 1:1 therapy and counseling was very apparent, as clients discussed the importance of having someone who they could talk to who they could trust, someone who knew them, and someone who had the information and resources
to help them overcome the symptoms of their mental illness(es), yet access to therapists is too far out of reach for many of the clients. The need for these services is imperative for mental health recovery, yet the people who need them are often not able to access them. Similarly, there are many community mental health services around the region that could greatly benefit the clients in this program and others in the community, but there is disconnect between the awareness of these services and the people who need these services. At the hospital, clients are told about a few services in the area, but not shown how to find these resources on their own or told about the various options available within their means.

**Experience of Mental Illness and Recovery**

**Barriers**

There was a lot of time spent talking about the barriers and challenges that the clients have experienced living with mental illness and while going through recovery. The symptoms of the mental illness alone presented many challenges for the clients, including the fear of the unknown, feeling unsure of oneself, feeling overwhelmed, feeling like they were unable to touch anything or talk to others, and being asked to be vulnerable even though it was a very uncomfortable feeling.

“The anxiety and depression is still extreme. And I don’t, when I’m in those moments of

“I don’t know what to do” I’m just overwhelmed with what skill do I reach for? Or I – I don’t even know what I’m looking for, I just, I’m in crisis.” – Samantha

In trying to deal with the symptoms of mental illness, many people shared that they use medication to manage their symptoms. However, sometimes the side effects of the medications would cause other symptoms that were unpleasant, such as weight gain fatigue, suicidal
thoughts, or for some people they felt no change at all. In some cases, these medications can be expensive as well. Another large expense, although one that many clients identified as necessary was the service of a one to one therapist. The lack of resources was a common theme throughout the focus group as people said they could not access a one to one therapist, or they did not know about other resources that could be available to them in the community, and did not know how to find out more information about the various resources in the community. Of the five people who were in the focus group, only one of them had a one to one therapist who they saw weekly.

“It makes me sad that not everyone has that opportunity, because it’s a stress and trauma clinic and they deal with trauma and I’ve never been to anyone who knew what they were doing until I met her. She knows how it affects your body and mind... I wouldn’t be where I am today without her. You really need to have a good GOOD therapist who knows what they’re doing. Yeah, you can’t not. And unfortunately it’s very difficult.” – Elizabeth

“How is it that we have so many services and yet nobody knows?” – Samantha

The theme of stigma was very apparent while the participants talked about their experiences living with mental illnesses. Stigma can be intrapersonal (within oneself), interpersonal (external people), or within institutions (by policies and rules put in place to limit someone). Self-stigma was quite apparent among the participants, by expressing feelings of low self-esteem, low self-confidence, low self-worth, and negative self-talk. A lot of the participants did not even realize how often they thought of themselves in negative ways, and said that it was just their version of normal to feel that way.

“I can’t walk down the street without feeling like that. Like the whole world, I don’t belong. I’m an alien. And I don’t belong here, I’m not one of them.” – Eva
“... Coming down that hallway the first time was absolutely terrifying. I was like, great, everyone is going to see me walking into Mental Health.” – Ariel

“It’s really hard to get past other people with the stigmatism. But I think it’s harder when we do it to ourselves. In society it’s easier to just, meh, push it under. But when you’re hard on yourself and you can’t get past that, I find that is the hardest thing to overcome.”

– Ariel

“I was meeting with a friend I hadn’t seen in a long time, and I was having a struggle because I was really embarrassed about where my life is right now. You know, when somebody says where are you living, what are you doing? Can’t work, can’t find a place to live, I’m in safe beds. Like, that’s embarrassing that my life has gotten to this point... It feels like I have to come out of the closet, and there will be all these judgements around it because this is what people think they know.” – Samantha

A lot of people had experiences of interpersonal stigma and barriers, among family members, friends, co-workers, and members of society, which they identified as being difficult to overcome and move past due to the lack of control that they have in the way that other people behave or respond to them.

“But when I put this into practice I get knocked down. That’s not a me thing, that’s an out there thing. I think we’re all fully aware, you can’t control anybody else. But how do I deal with it when I’m being knocked down, when I’m trying your skills and I’m told that I’m not allowed to? – Samantha

“I hate the word depression, cause depression means you don’t have any money, it’s the other person’s fault, depression means you lost your boyfriend... Until you say to
someone, I have depression, and they think, oh you’re just sad, get over it. You know, like, I’ve had chronic depression for 30 years. Do you know what that’s like to suffer for 30 years? And they have no clue.” – Eva

This feeling of barriers among people was also quite apparent among family members and friends. Clients stated that they felt like their family members and friends did not quite understand them or what they were going through, and that their judgements or misunderstanding caused feelings of loneliness, loss, alienation, and generally feeling unsupported.

“I didn’t talk to anyone from my family for 25 years. I had no contact, no hi, bye, not even knowing if they’re alive. They’re not there, it’s just me.” – Eva

“I had so many friends when I worked. But when I lost my job and then I got hurt and had to go for surgeries, and uh, it’s not the same. I don’t know, I can’t even describe it.”

– Norman

Facilitators

When talking about living with mental illness, the clients had some positive attributes that they felt they exhibited because of their mental illness. One of the common attributes among the participants was empathy. They felt like because they had experienced hardships in their lives, they were more accustomed to being kind to others, and understanding that everyone has hard times and challenges they face, so they approach others with more understanding and compassion as a result of their own experiences. The following conversation happened among the three participants in reference to empathy.
“I’m very much in tuned with your feelings. I have a hard time seeing people upset because of my own anxiety and depression and I – I feel too much.” – Ariel

“That’s me.” – Elizabeth

“Yeah, me too.” – Samantha

Some of the clients in the program also identify as mental health advocates, who will try their best to be open about the mental illness and being a client at the hospital as a way to help other people, including their own family members and friends. One client uses the tools and skills she has learned at the hospital as a way of helping her children deal with the challenges of adolescence and promoting positive mental health from a young age.

“I used to be that quiet little person, shoved in the corner, I’m not talking, I’m not letting anyone in, I’m not... But now, I’m very much, I’ll be the first one to say yes, I’m in classes at the hospital. Yes, you can benefit from them. Yes, you should go and get help. Like, I’m a very strong advocate for that.” – Ariel

Despite feelings of hopelessness or helplessness, there were moments throughout the focus group where the clients seemed hopeful about their recovery, or could identify moments of growth or progress from where they once were to where they were now. Norman, who did not continue with the study, stated that he would have been down a darker path if he had not participated in the hospital programs and he would not have done as well as he did if he had not gone to the classes. Other participants had similar experiences, stating that the information given in the classes was helpful for them and they found it useful, with one client saying that she learned something or took away something important from every program she was in. Even those who felt like they had not made much progress during their time at the hospital were able
to identify the importance of being in the hospital programs and facing their demons or challenges before being able to move on and recover.

Additionally, the clients agreed that more education about mental health and mental illnesses would help break down the barriers and stigmas surrounding mental illness, to help make the public more aware. They talked about commercials and advertisements that they thought have been helpful to capture the true experience of living with a mental illness, and various resources such as social media where people can share information about mental health and mental illness to help inform their friends on their networks. One client stated, “Education is to me, for mental health, education is empowerment.”

“People may not understand, but at least if even for what we get from all these classes and all this stuff that we’re doing for ourselves, even if we can explain it and they may not understand it, but at least we can talk about it like we know what we’re talking about so that that person may step back and say, wait a minute, and re-think what you said to them.” – Ariel

(Lack of) Expectations for the Community Connections Program

The final question of the focus group asked the clients what they thought the community connections program would be about. All the clients said that they had no idea what the group was about, but they hoped it would be beneficial. One client said,

“We’re all working on something. I think for me I just hope that whatever this group is and whatever it offers that it makes a few more connections for me than maybe previous groups did. And I don’t know, maybe makes things snap together a little bit more.” – Samantha
For the participant observation notes, I used a chart for each participant with the four categories of moments of full engagement, moments of realization (a-ha moments), moments of boredom and moments of confusion. Under each category there were spaces to indicate the topic and what happened to prompt a observation note. Each client had their own chart for each session, where I wrote down the notes during the time of the program. Then to keep the notes organized for the case study report, I would come home to type the notes on my personal computer, where I stored the information on locked documents. Upon analysis, I reviewed the participants’ observation notes to summarize the behaviour and responses that I observed throughout the program. Below are the summaries of the observation notes, as this information was used as descriptive results to triangulate the data.

Ariel

Throughout the program Ariel seemed to be quite engaged with the content, activities, and worksheets that were provided in each session. Her body language would always be open to the facilitators, she would keep her eyes on them when they spoke, and nodded along. She showed her excitement for the program content by smiling, laughing, and writing notes to keep track of the information shared and discussed in the group. Ariel participated in all activities and discussion, and would often give verbal feedback about her response to the various topics and discussions, such as saying, “I really liked this group today, it was fun!” Ariel would almost always complete her homework assignments, but even if she did not complete the work she would be able to reflect on her week and answer the questions or tasks for the homework during the discussion of the homework. Ariel experienced some confusion with aspects of the program, such as some of the terms used in assessments like the Leisure Interest Measure. Below (Figure 1) is an example of Ariel’s participant observation notes from session three of the program.
Elizabeth

Throughout the program Elizabeth was quiet with her responses as she later stated, she is introverted and likes to sit back and take in all the information that is being presented to her and discussed. At the beginning of the program Elizabeth was very quiet but became more open with the group as time went on. This was apparent from her body language and verbal responses, as she sat facing the group, engaged in pleasant conversation with the other participants and facilitators, and often smiled and laughed with the group. She was fully engaged in the sessions.

Figure 1. Example of Ariel’s participant observation notes from session 3.
by maintaining eye contact with the facilitators and having open body language as well as participating in the activities and some discussions. It was hard to read some of Elizabeth’s body language and responses throughout the program to see if she was enjoying the program or not as there were some mixed responses, which seemed to be true for her experience of the program, as she stated she generally enjoyed it, but there were parts that she could not relate to at this time in her recovery process. The only part of the program that she noticeably had trouble with was content related to goal setting. She stated that she has a hard time thinking about goal setting because she likes to think things through and process it before she decides to take action or her mind goes blank. Due to this, she sat looking at her page and up at the ceiling for a while. There were times when she did not complete her homework assignment, but she would follow along in the group and brainstorm ideas from her week to contribute to the conversation. Below (Figure 2) is an example of Elizabeth’s participant observation notes from session eight.
What happened: Made her own Christmas cards for family, friends, and groups at the hospital, and no two cards were the same. She also made brownies for our class. She loves doing things for other people and doing things homemade shows people that they are valued and cared for. Using many strengths in her leisure, it’s something she can do on her own and with others, and even when she does it on her own she is extending it to other people by giving them the cards.

Ariel pointed out many of the strengths she has and uses and it made Elizabeth emotional, brought her to tears which is not like her.

Topic: Review of Content
What happened: Looking through notes and nodding along. Stated she forgot about some of these things and Kelsey said “that’s why we do the review!”

Topic: Goal Setting for Future
What happened: Some hesitation at first but after some encouragement from Kelsey she came up with a goal and was able to do some more of the worksheet.

Topic: The CC Program
What happened: When Ariel stated she was grateful for the group and the facilitators for being so kind and welcoming, Elizabeth agreed.

Confusion
Topic: Goal Setting for Future
What happened: There was some hesitation at first and she became stuck on the first question asking about a specific goal. She said she was feeling stumped because she likes to have time to process and doesn’t like to do things on a whim, her mind goes blank. But eventually she did come up with a goal, even though it wasn’t particularly leisure oriented (eating healthier).

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**Figure 2.** Example of Elizabeth’s participant observation notes from session 8.

**Samantha**

Throughout the program Samantha had a combination of “aha” moments, full engagement, and some emotional triggers that seemed to upset her based on her life circumstances at the time. She always seemed engaged with the material by maintaining eye contact with the facilitators and group members, she would nod along and write notes, and would contribute meaningful insights to discussions and activities. Samantha was good at relating the information to her own life circumstances, but sometimes this ability would cause distress if the content did not relate to her life circumstances or triggered emotional situations in her past. She would show her disengagement from the material by looking around the room, pulling herself
away from the table or crossing her arms, breathing heavily, or at times leaving the room with tears in her eyes. She would sometimes show moments of boredom or confusion related to content that she could not relate with, which would often lead to feelings of frustration.

Throughout the program she was open with the group by sharing some of her experiences, and she would often explain herself or ask questions if she felt frustrated. Below (Figure 3) is an example of Samantha’s participant observation notes from session six.

<table>
<thead>
<tr>
<th>sounds, the sights, the feelings she had. She also talked about how she used to sing in a choir and it was something she loved to do so she was happy to do something she used to love. She was able to use her singing skills to do something she loved in the community with her family.</th>
</tr>
</thead>
<tbody>
<tr>
<td>She was in a very good mood throughout the session.</td>
</tr>
<tr>
<td><strong>Full Engagement</strong></td>
</tr>
<tr>
<td><strong>Topic:</strong> Community Resource</td>
</tr>
<tr>
<td><strong>What happened:</strong> She brought info about a book club at the library that she wanted to share with the group, and a video that was inspiring to her.</td>
</tr>
<tr>
<td><strong>Topic:</strong> Leisure Planning Process</td>
</tr>
<tr>
<td><strong>What happened:</strong> Writing notes. She requested a handout about the full process so she could practice it at home and keep the information with her. Others agreed with her.</td>
</tr>
<tr>
<td><strong>Topic:</strong> Scenarios for leisure planning</td>
</tr>
<tr>
<td><strong>What happened:</strong> Contributing ideas, nodding along.</td>
</tr>
<tr>
<td><strong>Confusion</strong></td>
</tr>
<tr>
<td><strong>Topic:</strong> Question asked was “think of a time where you didn’t plan and how did you feel?”</td>
</tr>
<tr>
<td><strong>What happened:</strong> Went a little off topic with her story, didn’t seem to get the question.</td>
</tr>
<tr>
<td><strong>Boredom</strong></td>
</tr>
<tr>
<td><strong>Topic:</strong> Levels of Motivation</td>
</tr>
<tr>
<td><strong>What happened:</strong> Seemed somewhat disengaged, shut down, or withdrawn due to looking down, her face became flush and her eyes narrowed which seems to be a sign for her.</td>
</tr>
</tbody>
</table>

*Figure 3. Example of Samantha’s participant observation notes from session 6.*
Although the three clients had different experiences of the program and all had different styles of participating in the program, it seemed apparent throughout the sessions that the clients were engaged with the materials, the discussions, and the activities of the program. The clients expressed their mastery of the content by being able to discuss the topics of the program related to their everyday lives and experiences, and they enjoyed activities that involved applicable and relevant information that they could utilize in their everyday lives. While there were some moments of boredom or confusion, it seemed to vary among the participants. Most of the confusion came from the descriptions or instructions for the assessments. For example, the clients were confused about the instructions and scoring for the Colours of Personality assessment. Most people forgot to do their homework, or if they did their homework task they would often forget to write it down in the Leisure Journal. The Leisure Journal was meant to remind participants to be mindful about their leisure experiences throughout the week and reflect on the experience to see the value of leisure in their lives. Ultimately during the time spent to review the homework, the clients would reflect on their experiences in the group, so it still acted as a good prompt, but perhaps the homework could be adjusted to make it more meaningful and memorable for the clients so they engage with the material at home during the events and environments of their everyday lives.

**SOCIAL VALIDATION**

**Summaries**

Throughout the program, Ariel seemed to be consistent with her social validation responses, particularly for the categories of “how important is this topic for recovery…” and “I understand this content…”, which were consistently scores of 4 or 5 (see Figure 1). Throughout
the sessions her confidence to engage with this content in her everyday life and her awareness or skills improved. At the beginning of the program her scores were around 2 or 3 (somewhat or moderately), and by the end her confidence and awareness or skills improved to 4 or 5 (highly to very highly) after the first two sessions.

![Figure 4](image_url)

*Figure 4. Ariel’s social validation responses for each session of the Community Connections program.*

Elizabeth was also consistent with her responses for the social validation responses (see Figure 2). Almost all her responses were a full 5 out of 5, representing that she felt like the content was very important for recovery, that she had very high confidence in her ability to implement these topics in her life, her skills or awareness of the content increased very highly, and she highly understood the content. She confirmed this in her interview by stating that she is a consistent person and generally very positive. The only sessions where her scores varied were for Goal Setting, Overcoming Barriers, and Leisure Planning, which was apparent in her responses during those sessions as she had more questions about the content and some difficulty with the tasks that they were asked to do. Samantha had a similar experience with the Goal Setting and
Overcoming Barriers session. Unfortunately, Ariel missed the Goal Setting session, but both Samantha and Elizabeth had some difficulty with those sessions, as the content was important, but her confidence, understanding, and skills or awareness of the skills was moderate to high rather than very high. This may suggest that more time may need to be taken to help clients develop skills for goal setting and overcoming barriers before diving into this content.

![Graph]

*Figure 5.* Elizabeth’s social validation responses for each session of the Community Connections program.

The social validation scores for Samantha were varied throughout the program, but show her progress and improvement throughout the program (see Figure 3). Her early responses were quite low for improved awareness or skill development or quite high for her confidence and stating the importance or understanding of the content. The importance of the content and her understanding of the content was generally high, but her confidence was moderate which was apparent in her behaviour and responses throughout the program. Both Samantha and Ariel had lower scores for the first session of the program, and as supported by clients’ responses from the
focus group, the first session is important for establishing the environment and the tone of the entire program, so is important that clients are given the necessary information while creating an open and inclusive environment to help the clients feel comfortable and open for learning and focusing on themselves while getting to know the other people in the room. Focusing on clients’ confidence from the beginning may help them put their focus and energy into themselves and the content rather than being nervous or anxious coming into a new program.

![Figure 6. Samantha’s social validation responses for each session of the Community Connections program.](image)

**INTERVIEWS**

**Clients’ Experiences of the Community Connections Program**

In general, the clients had positive experiences of the Community Connections program. At the beginning, as demonstrated in the focus group, the clients did not know what to expect
from this group as they did not know what the content was about, but they all said it was a good program during the time of their interviews. The clients agreed that they liked the program because there were less clients in the group compared to other programs at the hospital. In this case there were four to three clients in the program, which gave each person a lot of time to share their experiences and have time with the facilitator and other clients to get to know them better and feel more comfortable with them and talk about the content in a personal sense. They also appreciated the facilitator of the program as she was always kind, understanding, and took time to offer positive and meaningful advice and support to the clients. When the program went down to three clients, they all became quite friendly and open with each other, even getting together outside of the program to practice their leisure pursuits and make genuine connections.

“I enjoyed it because it was small. And I did participate. In other classes, you know it’s kind of… there’s so many people and there’s the people that will talk the most, and other people don’t often get an opportunity to say anything. And so I enjoyed that it was small like that and it seemed like we all had time to share.” – Elizabeth

The clients agreed that the topics covered in the sessions all had value in them, but they all really enjoyed the components that included self-awareness exercises. They all had similar ideas about continued learning and finding value in any kind of new information and listening to other people’s views to help see things differently, and said that they learned a lot from the program and from each other. One client did state that the program was good, but that the information that you feel like you can use or actually use depends on where you are in your recovery process.

During the final interviews, I gave the participants eight cue cards that listed the main topics from each session of the program. I asked the participants to rank the importance of each
session based on which sessions were the most meaningful for them and their recovery.

Elizabeth’s ranking of the program sessions based on what was most important for her and her recovery were as follows; Introduction to Community Integration and Self-Awareness, Strengths and Leisure, Community Resources, Overcoming Barriers, Friendship Building and Enhancing Leisure Experiences, Leisure Planning, Goal Setting, and Wrap Up and Reviewing Leisure Plans. Ariel’s ranking of the program sessions was Introduction to Community Integration and Self-Awareness, Overcoming Barriers, Community Resources, then the rest were tied, because she said she could not do any of the other things without those first three sessions. Samantha’s ranking of the program sessions was Community Integration and Self-Awareness, tied for second was Strengths and Leisure and Leisure Planning, then Goal-Setting, Community Resources, Friendship Building and Enhancing Leisure Experiences, Overcoming Barriers, Wrap Up and Reviewing Leisure Plans.

While the clients learned many valuable lessons throughout the program and enjoyed most of the topics, there were some that the clients struggled with. The clients had a difficult time with the concept of goal-setting as they felt it was an intimidating word that reflected big life changes that could sometimes be unrealistic or unattainable. Some clients stated that they felt like they were setting themselves up for failure and it would make them be hard on themselves if they did not accomplish their goals. The facilitators encouraged the clients to try to set small goals pertaining to leisure that they could accomplish by the next session one week later and broke down goal setting into baby steps to try to attain a larger goal. Throughout the program, all the clients met some of their leisure goals and said that they felt really good when they accomplished those goals, but still had some difficulty with the word, goal. One client recommended having the goal setting session closer to the end of the program to give people
more time to prepare for it. Elizabeth said, “I still trip up on the word goal. But yeah, I think about it differently now. I think it doesn’t have to be like huge, a huge thing. More attainable, yeah.”

All the participants from the program agreed that the program length should have been longer. The length of each session is one hour and 30 minutes, but participants agreed that it would be beneficial if the length of each session was closer to 2 hours long so that there could be a break in between the content and discussions, which is a similar format to other programs at the hospital. Considering how clients enjoyed how individualized the program was and that everyone had a chance to talk about their lives and experiences with the content and the topics of discussion, it would be beneficial to have more discussion time so that all of the content could be covered in addition to having time to discuss. One client also wished that the program length was longer than the 8 weeks.

Some participants stated that they wished there was more information about places in the community where a person could go to engage in leisure at low or no cost. During the Community Resources session of the program, the clients were given the municipal Leisure Guide that highlight different organizations, community events, and leisure spaces where people can go participate in leisure in the community. While this is a helpful resource, the clients stated that a lot of the programs and activities in the Leisure Guide were expensive and therefore they could not participate. One client stated that she thought this program would be a good opportunity to actually go out in the community to make connections with people and places in the community so that clients would feel more comfortable and confident going to these places on their own or with friends outside of the program time, but starting with that support from the group and the facilitators. She also suggested maybe changing the homework to start with
engaging in leisure activities, then progress into engaging in leisure activities in the community and find something that can continue week after week and encourage them to stick with it.

“The Leisure Guide is just one aspect of the community and it’s an expensive aspect. Like, you actually have to be able to afford to do things in the Leisure Guide. There’s like three free things in there. It’s not a guide for community, it’s not suggestions for how to connect, it’s just groups and fun things that are available at a very high price. So that didn’t really work for me.” – Samantha

They also stated that they wished there was more information about community mental health organizations to help with the transition from the hospital services into the community, and through that more leisure opportunities with similar people. A common topic from the focus groups and the interviews was how there are so many mental health resources available but clients did not know how to find them or how to access them, so it would be helpful if they could make an information sheet for the clients to learn about these resources and teach them how to find them on their own so they can pursue their needs.

“I feel like since I start my mental health journey last year all I’ve been doing is asking for resources, asking for help, and I didn’t even know the [name] existed. And then I called and they gave me all this information and I cried. I was like, how could I have been asking for these things for a year and I’m only just now finding them?” – Samantha

One client suggested that the program should also focus on developing interpersonal and intrapersonal skills that would be helpful when trying to connect with people and places in the community. She said, “How do we build on what’s uncomfortable, what doesn’t come naturally, what feels maybe wrong in some ways but isn’t wrong, you know? Coming to terms with those
She continued by saying that within the group it would be a good opportunity to practice interpersonal skills by talking to the people in the group, and working on some of the activities together to help build those skills.

The clients agreed that more people going through the outpatient mental health program at the hospital should be aware of this program as it was helpful for them in their recovery. One client said that she thought it would be good if the Community Connections program was the end program for everybody going through the mental health program for the following reasons:

“Because it’s more personal and gives us a lot of resources that a lot of people don’t know we have. And it kind of brings everything together. And it really concentrates on you as a person, I think that’s really really important before leaving this whole part of our journey... Like we don’t know the end of our journey and it feels like we’re kind of shoved out. But if you get to take a class like this then I think it better prepares you and you won’t have that anxiety at the end of it. Like I think it should be a mandatory one, that’s what I’m saying. Because I think it would help everybody coming through to be done with the whole hospital setting and to be okay with that part of their journey being done. And going into the community, it helps you recognize everything in yourself in the community, all the programs. And it’s a lot more comforting knowing the stuff that we’ve learned about ourselves and what’s out there for us.”

Impact on Recovery from the Community Connections Program

The use of leisure to help the clients with their mental health recovery was an important lesson that all the clients learned from this program. The individuality of the program and using
people’s interests to help them find or re-discover activities that can help them with their personal recovery was a benefit of this program that all participants agreed upon.

“... It’s kind of opened my eyes to different things that you know you can do for leisure or self-help. Like, you don’t think about how going for a walk or listening to music can help. You don’t have to just shut away the world from everything, so it kind of gives you a little bit more idea of what you can do to help.” – Elizabeth

“A lot of the groups have focused on self-nurturing and I don’t think I’ve really put a lot of effort into that because there’s never enough time. But when you’re sort of forced to do it as a homework piece, you know, week after week, it becomes a little more do-able. Having the chance to go through what all the leisure activities are, you know, sort of everyone’s thoughts on it, there’s a lot of things I never really processed as being self-nurturing. All of a sudden it was like oh yeah, that’s good for me!” – Samantha

“It’s given me that awareness that you know, if I’m having a moment I need to do something for myself... I think it comes down to what I said in the last class, you have to remember to take your medicine, even if it’s not a pill. And I think that’s really important for people in this situation because you know, popping a pill is so easy but it doesn’t really fix anything. But stopping and taking a minute for yourself, or 10, or an hour, it really does help to calm down your brain and I think it’s an important group more people need to be aware of.” – Samantha

This program has some self-awareness components that the participants really enjoyed, including assessments such as the Colours of Personality and the Leisure Interest Measure to remind the participants about positive parts of their personality, what is important to them, and
some interests that they may not have been aware of before, as well as areas of improvement that they could work on if they wanted to. The idea of self-awareness being highly important for recovery was consistent among the participants in the program.

“Like this one, introduction to community integration and self-awareness, that was the most important to me was the self-awareness. Taking away, like stepping back and being aware of yourself, everything around, like that to me is the number one. That’s the most important in my journey for me.” – Ariel

Additionally, the assessments helped the clients remember interests that they forgot about as their roles and life circumstances changed. Two of the participants are parents, and they both admitted that as mothers they gave everything they had for their kids and their kids were their top priority. This is a common experience for many mothers who balance the demands of motherhood with other roles such as work, partnerships, maintaining a house, and finding time and energy for leisure, as well as feeling a lack of entitlement for personal leisure practices (Lloyd, O’Brien & Riot, 2019). However, they stated that it is important to take care of themselves too, which was an important mindset shift to note in one client who would often refer to her responsibilities of being a mom as her leisure. She now understands that it is okay for her to do things for herself, but is trying to work on her feelings of guilt for doing things for herself instead of her kids.

“I’m just going to keep working on it so that I don’t feel so guilty if I’m out enjoying myself knowing my kids are in school and I should be home cleaning getting dinner ready, or whatever I think a mom should be doing. There’s more to me than a mom. And I guess Community Connections has kind of made me realize that there’s more to be than just being a mom. And it’s ok that there is.” - Ariel
Additionally, the participants stated that their leisure interests and priorities changed from before they acquired their mental illness, as there were things that they enjoyed doing before that they stopped doing after they acquired a mental illness, because they felt like they could not do it anymore or forgot what they liked to do before.

“You’re a mom, and everything is about your kids. You don’t think about yourself basically. You’re just trying to get through work and doing everything for your kids that you need to and you forget who you are and what you used to enjoy... So it’s interesting how you lose yourself and you forget, who am I? And then you read all those things and you’re like, oh yeah, reading, I remember I loved to read, or oh I didn’t know there was a category for me.” – Elizabeth

In relation to self-awareness, one client stated that she had not realized the impact of self-stigma in her recovery journey, and how her thoughts about herself had more power than she thought.

“It helped me realize, a lot of my depression and anxiety just is in my environment and what’s going on at home, or it comes down to how I think of myself as where I am. You hear that in other classes but to actually do what we did, brings bigger light to it on how to change your way of thinking... But we don’t take enough time to realize how our negative thoughts about ourselves impact us as much as they do.” – Ariel

One client stated that her involvement in the program has had an impact on the way she sees her progress throughout this recovery journey. She is focusing more on herself and taking care of herself in a way she did not do before. She used to be bothered thinking about what the end of her journey would look like, but she is not worried anymore as she understands that just
because she reaches the end of her pathway does not mean she needs to be 100% better and it is okay if she still struggles sometimes. She said,

“I thought that when you were done groups you were supposed to be all better, but Community Connection showed me like no, you continue working on yourself and continue doing those positive things in your life and just because it’s done doesn’t mean your journey is done.” – Ariel

When asked about lessons learned from the group that are most notable to her, or what skills or tools stick out for her, Ariel’s response was very profound in regards to her experience and the impact it had on her personal recovery. She noted the importance of self-awareness and how important it was to be truly happy. She said she gained the confidence to know and act on the premise that it is okay for her to do things for herself, considering she put so much of her identity and time into her kids before. Below is a direct quote from Ariel.

“And it’s… the whole thing has given me a new set of goals and a new, not necessarily what the end is going to look like because I don’t know, but I’m more excited to continue on with my journey because I don’t… This class has made me realize like my journey is never going to end until I’m dead. Like it’s a whole life type of thing. And I don’t think a lot of people see it that way, or I don’t even know if you’re supposed to, it’s just how I feel, that there’s no end for recovery for my situation. It’s an everyday learning and changing and embracing and it’s just going to continue for me, not end.”

Engaging in Leisure in the Community

Participants agreed that their participation in the program helped them learn about leisure and what leisure can do to help in the process of mental health recovery, and specifically what
kinds of leisure activities can help with coping. A lot of the participants had never really thought about leisure as a way to help them in their recovery, and for some participants they never thought about leisure at all, so this program helped them understand what leisure was, and what it could be and do for them in their everyday lives and their recovery. All the clients stated the importance of engaging in leisure and engaging in leisure in the community to help them in their recovery.

“I really wanted to try to figure out what this whole leisure thing was... No one explains what leisure is, you think oh that’s you just go and do something for the activity or the exercise... But I finally know what the idea is. It’s embracing everything around you. Like it might be different for other people, but that’s (hiking) one leisure activity that I can say I fully embrace in every way. That exercise, that clearing the mind, just enjoying the moment, and taking time for myself in that moment and it being ok. And really connecting with what I’m doing. And clearing all the negative energy. Just forgetting about everything and just being at one with whatever I’m doing.” – Ariel

“Sports. That was the big one, leisure was sports or something that you plan to do on sort of a weekly basis. And now I am seeing it more as, it can happen any time with pretty much anything and it’s just clicking into that, no I’m doing this for me and no other reason... It brings a lot more mindfulness to it.” – Samantha

The clients in the Community Connections program became more aware of some of the leisure opportunities that the community had to offer from the content of the program but also from the other clients in the program. They had discussions about the leisure activities they would participate in, which would bring more information and awareness to the other participants. One client said that there is never any talk about where to go in the community
when you are experiencing symptoms of mental illness that can help you feel better or just have fun in a place that does not have bad influences like a bar or spending lots of money. She said,

“If people know they can be more involved outside of the house, and still feel like you’re apart of something outside of these walls (referring to hospital) outside of everything outside, your family life, outside of whatever, your work life... There’s still stuff to do in the community that you can do and enjoy. And people are around and you can make friends that way or do stuff with your kids or your partner or your friends or whatever.”

— Ariel

After her involvement in the program, one client was still having some difficulty with leisure in the community, as she knew what she would like to do, but did not know where or how to access the type of leisure community she was looking for. She said, “I’d really like to start to get into a gardening group somewhere in my area but I don’t know that there is one. And this is what’s hard is finding the community for the leisure activity you enjoy, you know?”

**Skill Development for Community Integration**

Clients had a hard time answering this question as it was hard to remember all the skills and tools that were taught throughout the course. However, they agreed that they all learned something to help contribute to their recovery.

“We all have skills, it’s whether we choose to get involved. Like I do want to volunteer at some point, but I’m just not quite there yet... I think there’s probably already things that you have inside and then it just kind of maybe helps you to discover more about it or realize that’s what you could do.” — Elizabeth
One client stated that she was still struggling with the symptoms of her depression and anxiety, and discussed the impact of her past experiences in the community that are barriers for her moving forward and wanting to be part of the community. She stated that she knows it is important to be integrated with the community, but she was still struggling with overcoming that barrier. Additionally, she did not see all her skills and traits as being positive, so she had a hard time recognizing some of her traits as being helpful because of negative events from her past that she considered happened because of those traits of hers. However, she said that because of this group she has been trying to see these skills and traits as positive parts of her and it has helped her to become more aware of herself, and that the program has helped give her the desire to be a part of the community, rather than being on her own.

“Every week, either with the homework or in the class, there was sort of something to bring you back to your skills, to remind you of your skills. And I think looking back at my skills every week has sort of made me more aware of them and I feel like it’s moving in the progression of seeing them as me, and sort of, nobody else is going to see these strengths unless I do. For a long time, I’ve just felt like everything about me is an imposition to other people. So, I think coming into more conscious awareness of these things has really helped.” – Samantha

In reference to leisure and community integration, the clients agreed that leisure was a good way for people to get connected with their community. They stated that leisure was a good way to get out of the house and do something positive to get out of the cycle of depression or anxiety, and connect with other people that you know can help you or support you in your recovery, and this program helped them become more connected with the community by learning more about activities and places to go to be involved in leisure.
“Because it [leisure] does make you more mindful of what you’re doing, even if you’re not trying to be mindful about it. Leisure draws you into what you’re doing. And there’s lots of those kinds of activities in the community. So, if you find the leisure activity that you really enjoy doing then you can eventually hopefully transfer that to a community group or activity that you know is the same kind of thing... But to come together and do it together is important. And it sort of progresses that leisure activity on, and I think you can enjoy it with a group but also enjoy it on your own if that’s what you prefer.” – Samantha

COMMON THEMES

Based on the results from all forms of data collection, there were four main themes that were apparent about the impact of the Community Connections program for these clients. The clients learned about tools for self-awareness that they were able to use to identify their strengths, interests, and areas of improvement to help them in their mental health recovery. The clients learned about what leisure was, their personal leisure interests, and how they could leisure to aid them in their process of recovery. The clients also learned that leisure could be an important tool in helping them integrate with in the community. The last theme was that they believed the program needed to improve skill development for community integration by including an experiential component. Based on these results, the practitioners at the hospital can use this information to understand the needs of the clients at this stage of their recovery, and enhance the program to meet the clients’ needs to prepare for successful community integration, and have a greater impact in their lives.
CHAPTER FIVE: DISCUSSION AND CONCLUSION

This research project was designed to answer the question: what are the clients’ experiences of the Community Connections program? Through four forms of data collection and upon analyzing the data using my research questions, I have grown to understand and further explore the clients’ experiences of the program through their perspective and how it has and will impact their lives. While there were some findings that coincided with research from the literature review, there were findings that surprised me throughout this process as well. From these findings, I have some recommendations for future research as well as the future of the program to help enhance its effectiveness for the hospital and its patrons. I have also taken a moment to reflect upon this experience as it relates to my academic, professional and personal journey. Finally, I will discuss the limitations of the current study and make final conclusions.

Summary of Results

My main research question asked (1) What were the clients’ experiences of the Community Connections program? My sub-questions included (a) How does the Community Connections program effect clients’ recovery process? (b) How does the Community Connections program support skill development for community integration? (c) How does the Community Connections program shift clients’ perspectives about engaging in leisure in the community? Ultimately, all the clients learned valuable information from the program, even if they did not necessarily meet all the goals of the program. The goals of the program are as follows: (1) To teach clients skills to be able to find leisure resources in the community, and (2) To teach clients skills to engage in leisure independently and with others in the community, in order to break down barriers to community integration. The clients left the program wanting
more resources and skills for finding community programs that were accessible and realistic based on their needs and abilities.

The clients expanded their knowledge and understanding about what leisure is, their personal leisure pursuits, and how leisure can help them with recovery, and were starting to implement those skills in their everyday lives. The components of the program that focused on self-awareness were very impactful for all the participants as they started to see themselves in more positive ways. They did this by focusing on their strengths and positive attributes, and having resources that they could refer to throughout this process to help remind them of those positive traits instead of engaging with negative self-talk. They learned about the importance of self-care and finding parts of their identity that they had forgotten, including past leisure interests or changing familial roles. The clients were able to participate in various independent leisure activities at home and in the community, but some still felt some barriers related to community integration.

All the clients seemed to be at different stages in regards to community integration through leisure or otherwise. Some were still trying to manage the effects of their mental illness while some were going out and making friends in the community through their leisure pursuits. Even though they were all at different stages and some were more ready for parts of the program than others, everyone learned something that was valuable for them to help with their experience of recovery. The clients had a few recommendations to help enhance the program, which will be discussed later in this chapter.
MAJOR FINDINGS

SELF-AWARENESS

Self-Awareness and Self-Efficacy

Developing self-awareness is an important aspect of the recovery process. Self-awareness can be defined as awareness of one’s emotions, thoughts, and behaviours, and can be considered a state of being (Richards, Campenni & Muse-Burke, 2010). Caldwell and Hayes (2016) suggest that “self-awareness enables individuals to establish an overarching purpose for their lives that serves as an ongoing motivation for their priorities” (p.1167). Similarly, self-efficacy refers to a person’s confidence in their ability to perform certain behaviours or make certain changes in their lives (Bandura, 1977). Having this confidence is an essential part in motivating and enabling people to make the necessary changes to experience personal recovery (Villagonzalo, Leitan, Farhall, Foley, McLeod, & Thomas, 2018). As supported by Villagonzalo et al. (2018), higher levels of self-efficacy suggests greater self-esteem, positive goal-setting abilities, and persistence when faced with difficulties, all of which support the recovery process. Lower levels of self-efficacy may to lead to a sense of helplessness and failure, and a lack of motivation to persist with difficult tasks, which could hinder the process of recovery (Villagonzalo et al., 2018).

Self-efficacy and self-awareness are constructs that shape one’s identity, promotes self-development, enhances environmental mastery, connection to ideals, and mind and heart-based actions (Caldwell & Hayes, 2016) that can help individuals experience personal recovery. As stated by John, Navneetham and Nagendra (2017) interventions that focus on self-awareness help clients achieve autonomy, which is an important part of the recovery process and
community integration. Based on these findings, it is important for healthcare providers to promote self-efficacy and the self-awareness involved with the recovery process (Bali, Kohli & Malik, 2017).

The participants in this research study continued to note the impact of self-awareness for their process of recovery. By being encouraged to see their traits in a positive way and to continue reflecting on those strengths throughout the program, the clients stated that they felt more positive about themselves or that they were starting to recognize the importance of seeing themselves in a more positive way, which helped increase their confidence and self-efficacy. The clients stated it was important for them to experience enhanced self-awareness before they could move on to the skills needed for the next stage of recovery.

Research literature supports different ways that healthcare providers can enhance self-awareness and self-efficacy for individuals who have a mental illness. An example for enhancing self-efficacy involves positive peer models who have gone through the experience of personal recovery to empower clients and provide personal insight into the experience of personal recovery, thereby providing a sense of confidence that recovery is possible (Villagonzalo, 2018). Peer support helps promote empowerment, self-efficacy and helps combat internalized stigma (Burke, Pyle, Machin, Varese & Morrison, 2018).

Research also suggests the importance of self-reflection, seeking positive, honest feedback, and understanding one’s narrative identity to enhance self-awareness (George, 2015). Self-reflection is a practice that enables a person to focus on the important things in their life and helps develop a sense of well-being, by changing reflections from being angry or anxious toward a sense of calm and acceptance. Reflection can occur through use of a journal, prayer, going for a walk in nature, or mindfulness practices such as meditation. Next, seeking positive, honest
feedback can help a person develop self-awareness by seeing traits that one is unable to see in themselves, but that the people who are closest to them who they trust may be able to see and articulate those traits to the individual (George, 2015).

Understanding one’s narrative identity is a way in which a person can understand their life story. McAdams and McLean (2013) explain that the stories one tells themselves are a reflection of their personality and helps people shape the frame of mind that they use to understand their life stories and develop goals for the future. One’s ability to confront their life’s challenges is a reflection of their level of self-awareness (George, 2015). Research suggests that to start developing and understanding one’s life narrative they can think about the people, events, and experiences that have had the greatest impact in shaping them to be the person that they are. Additionally, one can think about experiences that they felt most passionate about leading in their lives, and asking how they frame their mind toward the challenges and setbacks in their lives (George, 2015). The practitioners at the hospital could use these suggestions to help enhance the self-awareness of clients in the mental health program throughout their time in the outpatient mental health program to create a more effective and efficient program for personal recovery.

**Identity Loss and Formation**

The theme of identity loss and formation is important for mental health recovery as well, and was prevalent among the research participants. A conceptual framework of personal recovery outlined by Leamy et al. (2011) describes identity as one of the key components of recovery. As stated by Farone and Pickens, (2007) “Becoming a part of the mental health system is often experienced as an internalization of a stigmatized label and a further devaluation of the
Individuals who are diagnosed with a mental illness often lose their sense of self as the symptoms of mental illness may conceal or distort an individual’s skills, knowledge, values, and attributes, and often describe their illness as taking away their previously held identity (Hine, Maybery, & Goodyear, 2019).

The participants in this study stated that there were parts of their identity such as traits and interests that they had forgotten due to the symptoms of their mental illness or their changing roles throughout their lives. The mothers of the group stated that when they became moms, they put all their energy and focus in their childrens’ needs and their kids leisure pursuits, therefore sacrificing their own needs. The pressures associated with modern parenting and what it means to be a “good mom” create an intense desire to be viewed as competent, which had effects on women’s identities by making them more susceptible to criticisms by others and themselves (Hine, Maybery, & Goodyear, 2019). This is further supported in the research literature as mothers have various constraints that limit their access to leisure, recreation and other self-improvement practices, due to lack of time and the demands of motherhood in addition to full-time or part-time jobs, which can have detrimental affects on women’s mental, physical, and social health (Currie, 2004).

Research suggests that by determining the direction of one’s life, grieving for lost opportunities and wishing for belonging and acceptance comprise the process of redefining and reclaiming one’s identity (Wisdom, Bruce, Saedi, Weis & Green, 2008). The clients stated that their involvement in this program has helped them re-discover their old interests and parts of their personality that they had forgotten about before using the assessments that highlighted leisure interests and personality traits and reminded them what was important to them. Research shows that a person who has a more positive sense of who they are, is less vulnerable to
internalizing social stigma and other negative stereotypes (Hasson-Ohayon, Mashiach, Lysaker, & Roe, 2016).

Throughout this program, the clients stated that they had not realized the impact of their self-stigma and were working towards seeing themselves in more positive ways to enhance their self-worth by exploring personally meaningful leisure. Identity work in mental health programs that integrates past experiences, challenges individuals’ assumptions regarding their identity (Tan, Gould, Combes, & Lehmann, 2014), and reflecting on emotional and behavioural responses are core components of the recovery process that can help individuals redefine their identity and promote their sense of self (Leamy et al., 2011; Shepherd, Sanders, Doyle, & Shaw, 2016). Integrating these practices in the hospital’s outpatient mental health programs would help enhance the program’s effectiveness for long-term improvement of people’s mental health and wellness.

**Readiness vs Outcome**

Throughout my observations of the program and upon analysis I thought that there would be a relationship between people’s readiness to integrate into the community and their perceived Stage of Recovery as outlined by Andresen, Caputi and Oades (2006), but this was not the case for every participant. Research findings from a study conducted by Llyod, King and Moore (2010) show that scores on the community participation measure had a somewhat weaker association with other indicators of recovery, showing that the relationship between recovery and community participation might not be as closely related as I had thought.

As stated in the literature review, factors such as family life, social health, physical conditions, financial, and vocational factors have an important impact on clients’ readiness to
discharge from clinical settings (McMinn et al., 2017). I thought that clients who were in the later stages of recovery and the had positive factors such as family life and physical conditions would be more prepared for the concepts of community integration and more confident in their ability to apply these concepts in their everyday lives. However, one of the clients who seemed to be in the later Rebuilding stage of recovery did not feel confident in her ability to use the community integration skills at this point in her life. Interestingly, one of the clients who I thought would not be completely open to the idea of community integration as she appeared to be in the Rebuilding stage but had multiple constraints in her life circumstances, seemed to be the most prepared as she was already implementing skills and goals related to community integration and leisure, and felt confident in doing so. The other client who appeared to be in the Preparation stage of recovery was in line with my prediction as she stated she was not ready for community integration based on the factors in her life and the symptoms of her mental illness.

Research conducted by Andresen, Caputi and Oades (2010) supports this, as they compared various measures of consumer-defined recovery with clinical measures, which found that there was little relationship between the consumer defined recovery and the clinical measures, which supported clients’ claim that clinical measures were too disability focused and did not focus on important aspects of recovery as defined by the clients themselves. Based on my own observations and pre-conceived notions of the program, I thought that the clients’ apparent Stage of Recovery would indicate their readiness to integrate into the community, but upon learning what was important for the clients in their personal recovery, these components were not necessarily congruent with the expectations from the hospital or the research literature. This finding helps enforce the need to use assessments that are recovery oriented to give evidence to service providers about the needs of clients during the recovery process to ensure that the
experience is personally meaningful for the clients, which will help improve recovery outcomes such as preparedness for community integration (Andresen et al., 2010). Additionally, upon analysis, the clients who did not feel ready to use the community integration skills had lower scores in confidence in their ability to use the skills learned in the program from the social validation questionnaires. This finding enforced the impact of self-stigma and self-efficacy on the clients’ personal recovery and their readiness to integrate into the community.

**Interpersonal, Intrapersonal, and Leisure Constraints**

It is also important to address the impact of constraints for individuals who want to integrate into the community using leisure, and for practitioners to understand the potential constraints that their clients may experience so they can help them overcome those barriers. Crawford and Godbey (1987) classified constraints into structural, interpersonal and intrapersonal. Structural constraints include factors that are external to the individual such as money, limited resources, and accessibility issues. Interpersonal constraints are related to an individual’s social isolation and a lack of knowledge for the opportunities to be involved in leisure. Intrapersonal constraints are internal to the individual which includes perceptions related to skills and abilities, and self-esteem (Alexandris, Du, Funk & Theodorakis, 2017).

Crawford, Jackson, and Godbey (1991) developed the hierarchal model of leisure constraints, that explain how constraints influence an individual’s decision-making to participate in a leisure activity using the following hierarchy: Intrapersonal constraints are considered first and mainly influence the preference for participation. Structural constraints such as finances limit participation rather than block it, and these constraints are usually the least powerful. Lastly, interpersonal constraints influence the preference for participation as well as different
aspects of participation, such as frequency and intensity (Alexandris et al., 2017). Considering this hierarchy of leisure constraints, community integration programs that utilize therapeutic recreation should consider these constraints when assisting clients with the community integration and recovery process, to help clients overcome these constraints and become fully engaged in the community, and experience a full and sustainable recovery.

The impact of self-stigma is very powerful for clients going through rehabilitation services, as they have often lived with their mental illness for many years and the symptoms of their mental illness have become a part of their identity (Iwasaki et al., 2010). It is widely supported in the research literature that stigma and social exclusion are major barriers that influence an individual’s recovery from mental illness (Lucksted, Drapalski, Calmes, & Forbes, 2011; Hasson-Ohayon et al., 2016). Based on the clients’ previous experiences in the community where they have experienced social exclusion, and feelings of loneliness or alienation, they have significant fears about trying to integrate back into the community. Research shows that many individuals who have mental illnesses feel the same way as they experience feelings of loneliness, alienation or being neglected, and struggling for equality in the community (Granerud & Severinsson, 2006).

It was apparent throughout the program that the feeling of fear or rejection in the community was holding the participants back from believing that they have the skills or ability to integrate in the community through leisure, given that they felt confident in their ability to use leisure as a tool to aid their recovery process and experienced enhanced self-awareness as a result from the program. A study done by Connell (2005) supports this claim, as participants in his study noted that if they were able to overcome the barriers they experienced such as lack of self-confidence, they would be able to accomplish the things they wanted to, to help them
become the person they wanted to be so their quality of life could improve. As noted prior, self-stigma and social stigma are major barriers for individuals who are going through the recovery process as it affects psychological and psycho-social well-being (Pérez-Garin et al., 2015; Livingston & Boyd, 2010).

It is important to note the need for mental health programs to help support clients with these challenges by encouraging independence and autonomy while helping clients develop social skills that they will need to connect with others in the community. As stated in research studies, individuals’ ability to be socially included in the community has an important correlation with improving mental health and enhanced well-being (Granerud & Severinsson, 2006). To address self-stigma directly, some anti-stigma programs that include education to counter the myths of mental illness with facts, and cognitive behavioural therapy approaches to challenge internalized stigma and reframe the ways a person thinks about themselves have been effective in helping clients confront the challenges of self-stigma (Mittal, Sullivan, Chekuri, Allee, Corrigan, 2012; Yanos, Lucksted, Drapalski, Roe, Lysaker, 2014).

Additionally, due to the suggestion that people who are out with their mental illness experience less self-stigma and a greater quality of life (Corrigan et al., 2010), programs that support individuals with becoming open about their mental illness by teaching them the pros and cons of disclosure, different aspects of disclosure, strategies for disclosure, and helping people frame their life story in a positive way may be helpful (Corrigan et al., 2015). For example, the program Coming Out Proud comprises manual, workbook, fidelity instruments, and a training plan, and has had positive effects such as reductions in depression (particularly for women) and improvement in stigma-stress appraisals such as experiencing less of a negative impact when they did experience stereotypes and prejudice from others (Corrigan et al., 2015). It would be
beneficial for the programs at the hospital to confront self-stigma and social-stigma directly using some of these evidence-based practices to help the clients prepare for interactions with others and how to handle those situations so they are less intrusive with their personal recovery.

**LEISURE AS A TOOL FOR RECOVERY AND COMMUNITY INTEGRATION**

**Prior Knowledge of Leisure**

Coming into the Community Connections program, the participants did not have much of an understanding about leisure. Many of the participants thought of leisure as sports or time spent doing nothing at all. When introduced to the concept of leisure from a therapeutic recreation perspective, the participants were very intrigued and found the information to be valuable for their personal recovery. When asked about some of the most meaningful aspects from the program, the concept of leisure and using leisure as a tool for recovery was a common theme. While I was happy to know that they clients learned some valuable information about the therapeutic effects of leisure, upon analysis I found myself questioning why they did not know this before, given that there are multiple therapeutic recreation programs at the hospital that they could have taken before. This supported the need to inform more people about the therapeutic effects of recreation and leisure, and for this hospital to confirm that clients have taken other therapeutic recreation programs to ensure that they understand the concept of leisure before moving on to this program.

**Leisure as a Tool for Recovery**

As clients learned more about leisure and its therapeutic benefits, they were expressing their lessons learned throughout the program. The clients were often happy to realize that many
of things they do in their everyday lives could be considered leisure, and if they were mindful of their experience, they could use those everyday activities and their strengths to help them enhance their positive emotion, connect with others socially, and alleviate the symptoms of their depression and anxiety as a tool for coping, which is widely supported in the research literature.

As stated by Fenton, White, Gallant, Hutchinson and Hamilton-Hinch (2016a) there are many forms of sport, physical activity, social, and creative activities that can be meaningful and have a positive impact on individuals’ mental health. Some examples of activities the clients in this research study did to help experience positive emotion were baking, walking or hiking, singing, playing games, taking a bubble bath and crafts or scrapbooking. There is research evidence from multiple scholars that show evidence to suggest the positive effects of leisure and recreation for mental health, such as fostering a sense of community (Elime, Young, Harvey, Charity, & Payne, 2013), connecting with others socially, and opportunities to develop social skills, (Fenton et al., 2016b). Physical effects from physical activities include alleviating symptoms of depression and anxiety (Conn, 2010a, Conn 2010b), improved mood (Penedo & Dahn, 2005), and increased energy (Street, James, & Cutt, 2007).

Additionally, leisure motivation toward personal confidence and hope, and goal and success-oriented leisure had the strongest correlations with recovery in a study conducted by Lloyd et al. (2007). As stated previously in the literature review, by being more engaged in the community, having a meaningful role within a leisure context, and experiencing feelings of mastery, positive emotions, and strengths, it may help people feel less stigma within themselves and within social groups, which will help with life satisfaction and psychosocial and emotional well-being (Hood & Carruthers, 2004).
SKILL LEARNING FOR COMMUNITY INTEGRATION

Lack of Skill Learning for Community Integration

When completing the final interviews, I asked the clients two questions related to skill development and how the Community Connections program may have contributed to their skill development related to community integration. The clients highlighted their skill development related to self-awareness and leisure, but were not able to identify specific skills related to community integration. While self-awareness and leisure are two important skills that clients need for community integration, I was surprised that there were not more direct skills related to community integration that the clients could identify as important skills from the program.

Two of the clients stated that they wished the program had more specific information about community resources and community organizations that could assist individuals with getting integrated into the community, whether through leisure or other mental health resources. Research from Pinfold et al. (2015) supports this by suggesting that multi-agency integrated solutions to support individuals who have mental illnesses with social recovery practices would help clients integrate into the community and support well-being by developing social networks and community integration skills. Dickey and Ware (2015) state that for individuals living with mental illness, the notion of living in the community goes beyond living outside of a clinical setting by finding a community that encourages being in a relationship with others in the community. Living in these intentional and informal communities allow individuals to learn and grow and make the changes necessary to experience sustainable recovery, and the inclusive culture helps keep individuals accountable, making the experience of recovery a therapeutic agent (Dickey & Ware, 2015).
This is an important consideration for the future of the program, to help the clients not just by giving them a list of the resources they may want or need, but helping them develop the skills they need to be able to find these resources on their own and use their skills in the community to help them build their social networks, promote autonomy, and enhance well-being.

**EXPERIENTIAL LEARNING FOR COMMUNITY INTEGRATION SKILLS**

To further support this, clients in the program said that a more experiential component of the program where the clients could go out into the community with the support of a facilitator and practice these skills by planning leisure outings and practicing interpersonal skills would be beneficial for them. Experiential learning is widely regarded in research literature as an effective way to learn skills, particularly in adult education (Kuk & Holst, 2018). Reflection of the experience is a key component of experiential learning (Kuk & Holst, 2018) that the clients in the Community Connections program used through the use of weekly journals to keep track of their leisure engagement and how they felt before and after the activity, reflecting upon the skills and strengths they used to engage in that activity, and to identify any challenges they may have experienced so they could learn how to overcome those barriers in the future. As stated by one of the clients, they said they wished the homework task asked clients to step outside of their comfort zone and engage in leisure in a community setting or with another person to promote skill building for community integration. As stated by Ornelas, Vargas-Moniz, Duarte, and Jorge-Monteiro, (2019) “the opportunities to participate in community contexts are essential to achieve more lasting and significant purpose in terms of personal empowerment and community integration” (p. 45), therefore creating a greater impact in the clients’ lives and recovery.
A Model for Program Evaluations

Based on the comprehensive findings from this study, one of the major outcomes of this thesis is providing practitioners and other researchers with a model for conducting program evaluations that integrates program design with service. By using the combination of a focus group, participant observations, social validation questionnaires and individual semi-structured interviews, I was able to gain a deeper understanding of the clients’ experiences of the program beyond the common program evaluation practices. While obtaining information about the clients’ thoughts about the components of the program, I was also able to obtain information about the meaning they derived from the program and how that related to their personal experience of mental health recovery. Getting the clients’ insights about the program and how it was contributing to their recovery helped empower them to become active agents in their own care as well as contributing to future clients’ care. With multiple methods of data collection, every participant has a chance to contribute to the program evaluation in a way that is congruent with their strengths and abilities. Using this approach by allowing the clients to utilize their own strengths for the program evaluation is in line with the philosophy of strengths-based, client-focused care that is prevalent in the therapeutic recreation field.

Recommendations for the Community Connections Program

Based on the data collected from the research participants, my personal reflections, and the research literature, I have a few recommendations for the future of the program. First, the clients all agreed that making the program two hours long, once per week, would be beneficial for the flow of the program. With eight sessions in the program and important information to cover, the extra 30 minutes would help the facilitators cover all the content of the program, while
also allowing for valuable discussion time amongst the clients and the facilitators, as well as time for a short break.

As mentioned previously, an experiential component would be beneficial for the results of this program to help clients develop the skills they need to confidently integrate into the community through leisure. As many clients have had negative experiences in the community and do not feel like they belong in the community, it would be beneficial to go into the community as a group to experience some of the leisure spaces that the community has to offer with support from the program facilitators and each other to help combat their intrapersonal, interpersonal, and leisure constraints as supported by Pinfold et al. (2015) and Ornelas et al. (2019). It is important to note that professionals working in mental health settings should address individual rehabilitation services as well as community-based services to encourage the clients’ ability to access recreation and health promoting opportunities in the community, to not create a reliance on the practitioner (Reid & Alonso, 2018). Creating a holistic approach to healthcare is consistent with the philosophies of therapeutic recreation, by valuing the person first but understanding that a person’s environment and community is important to their experience as well (Reid & Alonso, 2018).

Additionally, as clients’ readiness to integrate into the community seemed to correlate with their stage of recovery, it would maximize the benefits of the program if clients were recommended for the program after they have gone through their pathway to care and have been in other therapeutic recreation programs. By addressing some of the components of recovery in other programs, such as self-awareness, identity, meaning-making, empowerment, and connectedness, the clients would be able to come into this program ready to learn about community integration skills and better able to overcome interpersonal, intrapersonal and
structural constraints that could limit leisure participation in the community. Furthermore, as clients seemed to learn a lot about leisure and how it could help them in their recovery, it would be beneficial if they could learn that in an introductory program and then move on to the Community Connections program when they were ready to learn more skills about how to use leisure as a way to integrate into the community. While the clients found the information to be valuable, they stated that they were not ready to use these skills, mainly based on still trying to manage the symptoms of their mental illness, and their previous experiences in the community that have left them with feelings of fear or rejection. If clients come into the program with tools to help manage the symptoms of their mental illness and already have an introduction to the concepts of leisure, it would help to maximize the impact of this program for the clients, which in turn would help to maximize the effectiveness and efficiency for the hospital programs and clients’ recovery.

Current research literature suggests different practices to improve community integration programs such as the need to have a physical presence in the community, sustainable relational strategies with community members, and the sense of effectiveness and belonging in the community (Ornelas, Vargas-Moniz, Duarte, & Jorge-Monteiro, 2019). Multiple researchers enforce the importance of fully participating in community life, accessing meaningful resources, activities, and settings that are inclusive for all community members to facilitate social engagement in community-based settings, and strengthen individuals’ sense of belonging in the community (Brown & Rogers, 2014; Ornelas, Duarte et al., 2014; Ware, Hopper, Tugenberg, Dickey & Fisher, 2008).

Additionally, the use of electronic or tele-mental health services has been suggested as an effective tool to assist clients during their process of recovery and their daily living (Gucci &
Marmo, 2016). Studies have demonstrated how these tele-mental health services have been effective in providing clients with access to various resources, improves basic outcomes of the program and are generally well-accepted with clients (Gucci and Marmo, 2016). In the study conducted by Gucci and Marmo (2016) the researchers found improvement in outcomes after six months observation with the participants in the areas of decreased hospital admission and hospitalization length, reduction in day-hospital admission and a notable effects on outcomes of empowerment, quality of life, social relationships, internalized stigma, and global functioning capabilities based on various assessments. Gucci and Marmo (2016) suggest that a dedicated website in mental health programs can support clients in their own living spaces which would have less impact on daily activities, decreases social costs, encourages community integration and reduces stigma, which would be very beneficial in supporting clients in the Community Connections program to help mitigate some of the areas for improvement that were identified throughout the program, and help them build the skills they need for community integration.

**Limitations and Recommendations for Future Research**

Considering that this is a single case-study, the findings from this project are not generalizable. Recommendations for future research include having a larger sample size for the program in order to gain more insight from a more diverse population, as this sample size was small and only consisted of Caucasian females. Based on the group dynamic of having only females in the study, I recognize that the findings of this study would likely be different if there were diverse participants present throughout the research process. I recognize that the results may have varied if there were research participants of other ethnicities, faiths, genders, socio-economic classes, races, etc. Therefore, collecting data from multiple, diverse groups would help enhance the strength of the findings for future case-study program evaluations. Future
researchers could also conduct a longitudinal study, where they follow up with participants a few weeks or a few months after the completion of the program to see which parts of the program were most valuable to them and which skills they were continuing to practice over time, rather than one to three weeks after the completion of the program. Future researchers who wish to conduct a thorough case-study evaluation could use this research design as a model to use multiple sources of data to triangulate and support their findings in a way that uses the researcher’s expertise with the participants’ personal experiences. Using multiple methods for evaluations of programs could help give practitioners a more thorough and comprehensive understanding of the clients’ experiences of the program while using their own understanding and expertise to continue enhancing their programs to their maximum capacity. Additionally, using multiple methods of data collection for program evaluations allows the clients to provide information using their own strengths and levels of comfort to be able to contribute to the evaluation in ways that are more suitable to their abilities and needs. Using client-focused methods of program evaluation help to encourage person-centred care and strengths-based practices to empower individuals to be active members in their care. Experts in the therapeutic recreation field suggest that this research design could act as a model for future program evaluations.

**Personal Reflections on Research Process and Experience**

Completing this master’s degree has been a life changing experience. I experienced a lot of highs and lows throughout these past three years, but all have contributed in shaping me into the resilient and grateful person that I am today. I started my master’s degree with the intention of completing a quantitative research thesis and completely flipped to a qualitative research thesis about half way through my degree, proving to myself that my abilities are diverse and that
I can adapt to new situations. I have a hard time putting into words the loss I felt when Dr. Lane passed away, but I am comforted knowing the many lessons she taught me that have carried me throughout this master’s degree and will continue to carry me throughout my professional and personal life. I am so grateful for Dr. Colleen Hood for helping make the transition as easy as possible, and constantly providing support, encouragement, and guidance throughout the highs and lows of this experience and through my personal life. I can truly say that I would not have gotten to this point without her direction and care.

Having a mental illness myself, Dr. Hood was always supportive by ensuring that my mental health was good throughout this process, and understanding of the close personal nature of doing research in the mental health field while having a mental illness myself. The more that I work in the mental health field, the more I am empowered by the strength, resiliency, and growth that individuals have shared with me throughout my experiences. As someone who has a mental illness and lives well with my mental illness, I hope that I can support and encourage others through my personal experiences as well as my professional practice.

As a practitioner and a researcher, I have discovered the importance of reflecting on my own abilities and using my strengths to contribute to research and my practice in the safest, most effective way possible. Also reflecting on areas of improvement has helped me recognize where I need to ask for help and take action to learn and improve so that I can put my best foot forward in my research and practice. Doing this kind of project where I needed to keep in check with my potential for bias, it was important that I continued to be reflective to ensure that I was being as open minded and fair as possible, while also relying on my supervisor and advisory committee to remain objective. I had to remember that while I helped contribute to this program it was not my own, and told myself that it belonged to the hospital. Most importantly, I kept in mind that while
I hoped the program would be effective for these clients, I also hoped that I could identify areas for improvement to help the practitioners enhance the program so that it could be more effective and efficient for clients and the hospital system. I encourage therapeutic recreation practitioners to take time to reflect on themselves, their strengths and weaknesses, their defining moments, successes and failures, to take care of themselves and celebrate their hard and rewarding work, and know that taking that time to reflect can help them be the best that they can be for themselves and for their clients.

Another important lesson I learned from completing this research was the challenges of conducting field research. I learned that there is a fine line between being a practitioner and a researcher. As a practitioner and someone who was previously an intern at this hospital, I found I wanted to be involved with the implementation of the program and in the focus group and interview I wanted to support the clients as I would in my practice. However, as a researcher I needed to remain impartial and not let my emotions get in the way of the facts or implementation of the research. Particularly during the participant observations, I needed to sit at the back of the room and remain quiet throughout the program, even when the clients would ask me questions sometimes, or leave the room visibly upset. During the time of the focus group, participants disclosed very personal and vulnerable information to me, and the way that I would have acted as a therapist was different than how I needed to act as a researcher. Throughout this research I learned about the complexities of not just conducting research, but conducting research with a vulnerable population that will help me as I move forward in my career.

This project was the first of many I hope to do to help support individuals who may not feel like they have power or influence to do so. One client said something to me during her final interview that has stuck with me. She said, “It’s fine to say we need a hero for mental health but
those kind of heroes come from mental illness and we don't feel that we have the power.” I am grateful that through my education and personal experiences I have the power and the empowerment to try to make a difference in the lives of people like me who need someone to advocate for them and take action to make those changes come to fruition.

Especially after I conducted the final interviews with the participants in the program, I knew that not just their involvement in the program but their involvement in my research project helped them with their recovery and there is no greater joy than knowing that something that I was a part of has helped people feel better in one way or another. That is what doing research is about in this profession; finding ways to help people live the best life possible and using evidence to support the need for those kinds of practices and share that information with practitioners who can use it. That has been my biggest take away from this experience, the work is hard but so valuable in the lives of people who need a voice, who need support, who need us, and ultimately, I need them to help me fulfill my purpose to help people and contribute to the field of knowledge in the therapeutic recreation field that I am so passionate about. I am so grateful for my research participants and their willingness to open up to me and share their experience of recovery with me. I want to continue to provide service to people throughout my life, so I am very grateful for the skills I have learned as a researcher, as a future certified recreation therapist, and as a human being throughout these three years.

CONCLUSION

In conclusion, the Community Connections program had some strong concepts that had a positive impact on the clients’ experience of the program, but there were also some identified areas for improvement. The strengths-based, person-centred therapeutic recreation approach of
this program helped the clients feel valued, understood, and heard from the facilitators, and they felt more open and comfortable talking about their experiences and exploring their identities. The idea of community integration helped the participants feel more prepared for the next stage of their recovery, whenever it may occur for them, and that seemed to be an important theme throughout this project that will have a lasting impact in the clients’ lives. Everyone experiences recovery differently, and everyone is at different stages of their recovery, so it is important to help people based on the stage they are in and help provide the necessary supports to help them move onto the next stage. Comprehensive program evaluations that can include multiple methods that highlight the clients’ perspectives about what is important to them based on their needs along with the practitioners’ policies and guidelines can help enhance current rehabilitation services by providing effective and efficient care for all.
REFERENCES


http://search.ebscohost.com/login.aspx?direct=true&db=edsdoj&AN=edsdoj.11cf5a37d9de4c52a8f86728fbb8c122&site=eds-live&scope=site.


http://dx.doi.org/10.1037/prj0000100.


Appendix A

Phone Script for Recruitment

“I would like to inform you about a research opportunity, entitled Shifting from Agency to Community: Exploring the Impact of a Community Integration Program for Mental Health Recovery.

The purpose of this research project is to evaluate the Community Connections program and see how people’s involvement in the program contributes to their process of recovery.

Should you choose to participate, you will be asked to participate in a focus group, complete brief social evaluation measures after each session, and possibly participate in an interview after completion of the program.

Participation in this research is voluntarily and will not affect your involvement in the Community Connections program. All data collected will remain confidential.

At this time, do you think you would be willing to participate in this research?

If yes: If you agree to participate, the researcher, Julie Ostrom, will contact you directly with more detailed information about the project. Would you prefer she contact you by phone or email?

If no: No problem. Thank you for your consideration. We will see you when the program starts.

If you have any questions about the research or you would like to obtain more information, you can contact the researcher, Julie Ostrom. Her email is jo11hy@brocku.ca and her phone number is 519-903-5854. Colleen’s email is chood@brocku.ca

Thank you for your consideration.”
Appendix B

Focus Group Questions

1. What has it been like for you in the hospital programs?
   - What have been some good experiences for you?
   - What were some of the not so good things?

2. What is next for you after this program?
   - Out in the community?
   - More hospital programs?
   - Community-based programs?

3. How do you feel about moving on to the next stage of your recovery?
   - Excited? Nervous?

4. We often talk about recovery with mental illness being a process of recovery as opposed to an outcome.
   - What does that mean to you?
   - What has helped you with your process of recovery?
   - What would help you in recovery?
   - What are the barriers that you experience during your process of recovery?
Appendix C

Session 1: Introduction to Community Integration and Self-Awareness

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. How important is it to understand your personal strengths when working towards recovery?
   1  2  3  4  5

2. Do you feel like your self-awareness of your strengths and traits has improved?
   1  2  3  4  5

3. How confident are you that you can use the skills to practice self-awareness throughout the recovery process?
   1  2  3  4  5

Comments:
Appendix D

Session 2: Strengths and Leisure

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. I understand the theory of multiple intelligences

2 = 3 = 4 = 5

2. I understand how my strengths are reflected in my leisure.

1 = 2 = 3 = 4 = 5

3. I have the ability to identify my strengths.

1 = 2 = 3 = 4 = 5

4. I am confident that I can use my strengths to support community integration.

1 = 2 = 3 = 4 = 5

Comments:
Appendix E

Session 3: Community Resources

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. Understanding my leisure interests is important to me.

1  2  3  4  5

2. I understand how leisure can connect me to my community.

1  2  3  4  5

3. I have the skills to seek out volunteer opportunities in my community.

1  2  3  4  5

4. I am confident that I can access leisure resources in my community.

1  2  3  4  5

Comments:
Appendix F

Session 4: Goal Setting

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. Setting goals is important for community integration.
1 2 3 4 5

2. I understand the process of setting goals.
1 2 3 4 5

3. My ability to set goals related to leisure and community integration has improved.
1 2 3 4 5

4. I am confident that I can implement my goals related to community integration.
1 2 3 4 5

Comments:
Appendix G

Session 5: Overcoming Barriers

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. I understand the concept of barriers.

2. I understand how I can overcome barriers through leisure.

3. How much has your awareness of stigma changed?

4. I am confident that I can overcome barriers throughout my recovery.

Comments:
Appendix H

Session 6: Leisure Planning

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. How important is planning leisure experiences important for community integration?
   1  2  3  4  5

2. I know the process of planning a leisure experiences from beginning to end.
   1  2  3  4  5

3. I have a better understanding of the benefits of planning a leisure experience.
   1  2  3  4  5

4. I am able to plan my own leisure experiences.
   1  2  3  4  5

Comments:
Appendix I

Session 7: Friendship Building and Enhancing Leisure Experiences

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session using the scale below:

1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

1. How important do you think it is to savour your leisure experiences?
   1  2  3  4  5

2. I am aware of some techniques that I can use to savour my leisure experiences.
   1  2  3  4  5

3. Building social connections is important to me and my recovery.
   1  2  3  4  5

4. I am confident that I can use leisure to build and maintain relationships.
   1  2  3  4  5

Comments:
Appendix J

Session 8: Wrap Up and Reviewing Leisure Plans

Upon completion of the session, please indicate your level of agreement or disagreement to the following questions about the content of the session and the overall program using the scale below:

0 = not applicable, 1 = not at all, 2 = somewhat, 3 = moderately, 4 = highly, 5 = very highly

Include the overall topic social validation questions

1. How important is it to have future leisure plans to enhance your community integration?
   0   1   2   3   4   5

2. How much has your perception about community integration changed since the beginning of the program?
   0   1   2   3   4   5

3. I am confident about my ability to integrate into the community using leisure.
   0   1   2   3   4   5

4. I found the information in the group helpful for improving my wellness.
   0   1   2   3   4   5

5. I will use the information from the program to support my wellness.
   0   1   2   3   4   5

6. Program content was clear and understandable.
   0   1   2   3   4   5

7. I felt that my needs were met in the group.
   0   1   2   3   4   5
8. I felt comfortable in the group.
0 1 2 3 4 5

9. I would recommend this group to others.
0 1 2 3 4 5

10. The group leaders were organized and focused on the program material.
0 1 2 3 4 5

11. The group leaders are knowledgeable on the topics for this program.
0 1 2 3 4 5

12. The group leaders maintained a safe, open environment in the group.
0 1 2 3 4 5
Appendix K

Participant Observation Tracking Form

<table>
<thead>
<tr>
<th>Aha Moments</th>
<th>Full engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic:</td>
<td>Topic:</td>
</tr>
<tr>
<td>What happened:</td>
<td>What happened:</td>
</tr>
<tr>
<td>Topic:</td>
<td>Topic:</td>
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<td>What happened:</td>
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<td>Topic:</td>
<td>Topic:</td>
</tr>
<tr>
<td>What happened:</td>
<td>What happened:</td>
</tr>
</tbody>
</table>

Client: __________________
Topic: Confusion
What happened: 
Topic: Boredom
What happened: 

Topic: 
What happened: 

Topic: 
What happened: 

Topic: 
What happened: 

Topic: 
What happened: 
Topic: 

What happened: 

Topic: 

What happened:
Appendix L
Interview Questions

1. How would you describe your experience of the Community Connections program?

2. Has the Community Connections program contributed to your process of recovery, how so?

3. In what ways has your participation in the Community Connections program shifted your ideas about recovery?

4. How has the Community Connections program shifted your views about connections in the community?
   - How has this program shifted your views about engaging in leisure in the community?
   - Would you say that leisure is important for community integration? Why or why not?

5. To what extent do you feel like you have the personal resources and skills to successfully integrate into the community? What skills or personal resources contribute to feeling this way?

6. How has your participation in the Community Connections program contributed to your skills to integrate into the community?

7. What was the Community Connections program missing that could help you in your recovery?
   - If there was one session that you could change in this program which one would it be and why?
   - How would you change it?

8. Which aspects of the Community Connections program were the most meaningful to you? Why?
   - If you had to rank the importance of each session how would you rank it using these cards? Please explain your reasoning.
   - If there was only one session that remained in the program which one would you keep and why?

9. Is there anything else you would like to talk about to explain your experience in the Community Connections program?
Appendix M

Informed Consent Form

**Project Title:** Shifting from agency to community: Exploring the impact of a community connections program for mental health recovery

**Principal Student Investigator (PI):** Julie Ostrom, graduate student
Department of Leisure Studies, Brock University
jo11hv@brocku.ca

**Local Principal Investigator (LPI):** Robert Cosby, MSW, RSW, Clinical Manager
Outpatient Mental Health and Addictions Program, Niagara Health – St. Catharines Site
Office: 905-378-4747 ext. 49522, Robert.cosby@niagarahealth.on.ca

**Faculty Supervisor:** Colleen Hood, PhD, faculty supervisor
Department of Recreation and Leisure Studies, Brock University
(905) 688-5550 Ext. 5120, chood@brocku.ca

**INVITATION**

You are being invited to participate in a research study. The purpose of this study is to evaluate the success of the Community Connections program and see how people's involvement in the program contributes to their recovery.

**WHAT’S INVOLVED**

As a participant, you will be asked to participate in the program as you normally would (assessments, questionnaires, activities, discussions, homework), with the addition of a focus group before the program begins, and the possibility of individual interviews after the program has finished. The researcher will also conduct observations during the time of the program. All participants in the program will also be participants in the research study to ensure privacy and confidentiality. There will be between 4-8 people recruited for this study. Participation will take approximately 2 hours of your time, once a week, for 10 weeks.

**POTENTIAL BENEFITS AND RISKS**

Possible benefits of participation include greater awareness of various aspects of recovery to help you with your experience of recovery, and the potential to inform mental health practitioners about meaningful aspects of recovery to incorporate into their treatment programs. There also may be risks associated with participation in the form of emotional stress and feelings of worry or being upset due to being asked questions about your personal experience with mental health programs, the process of recovery including challenges you may have faced, and feelings about moving on into the community.

**CONFIDENTIALITY**

*Confidential survey/questionnaire:*
All information you provide is considered confidential. Given the format of this research, we ask you to respect your fellow participants by keeping all information that identifies or could potentially identify a participant and/or his/her comments confidential. Your name will not be included or, in any other way, associated with the data collected in the study. Also, because the researcher’s interest is in the average responses of the entire group of participants, you will not be identified individually in any way in written reports of this research. However, with your permission, anonymous quotes may be used.

Audio Tape Recording

Focus groups and individual interviews will be audio recorded for the use of the research data analysis. Recordings will be transcribed and written in a word document in order to group and analyze data. Your name or any personal identifiers will not be included in the transcription, instead fake names will be used to keep track of participants’ responses.

PROTECTION OF DATA

Data collected during this study will be stored in a password protected document on the principal student investigator’s personal computer, and paper documents will be kept in a locked filing cabinet. Data will be kept for six months, and after the six months the files will be shredded and deleted from all devices. Access to this data will be restricted to the principal student investigator, Julie Ostrom, the faculty supervisor, Colleen Hood.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or restrictions to the Community Connections program.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available from Julie Ostrom, whom you can contact via email (jo11hv@brocku.ca). Feedback will be available approximately 6 months upon completion of the program via email.

Please write yes or no if you would like to have the results sent you when the feedback is ready. If yes, please write your email below and sign and date this section. ______

Signature: _____________________________ Date: ___________________________

Email Address: _______________________

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Julie Ostrom or Colleen Hood using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [file #18-001] and The Hamilton Integrated Research Ethics Board [file #5155]. If you have any comments or concerns about your rights as a research participant, please contact the Brock Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca or office of the chair of Hamilton Integrated Research Ethics Board at 905-521-2100 ext. 42013.

Thank you for your assistance in this project.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time. I will receive a signed copy of this form.

Name: _________________________________

Signature: _____________________________ Date: ___________________________

WITNESS

Name: _________________________________
Signature: ___________________________ Date: ___________________________

INVESTIGATOR
Name: ___________________________
Signature: ___________________________ Date: ___________________________