



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Arts-informed narrative inquiry as a practice development methodology in mental health

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Submitted for publication: 25th November 2014

Accepted for publication: 31st March 2015

Abstract

Background: Congruent with the practice development movement, arts-informed narrative inquiry addresses practitioner awareness of self and others within the social context of mental health care. Through our research programme, which explores experience using creative activities and dialogue, we invite nurses to reveal how they shape and are shaped by organisational change. The personhood of the nurse is implicated in the relationship with patients and others.

Objectives: Participants and researchers renewed a commitment to enhance person-centred care through self-reflective practice, to make transparent the construction of knowledge and to transform the practice environment from the frontline perspective.

Methods: We used arts-informed narrative inquiry processes with our participants in five sessions over eight weeks. Three group sessions were in person and two were completed independently with online resources for guidance. The creative activities preceding group dialogue included: writing stories, metaphor development, collage, walking meditation, mandalas and music-guided art.

Findings/results: Arts-informed narrative inquiry illuminates the construction of practitioner knowledge and relationships within a mental health setting. Nurses articulated the autobiographical resonances they bring to relationships with patients and others, illuminating person-centred care. Heightened awareness of how nurses' agency is connected to their values, other caregivers and organisational policies and practices was evident. The potential for transfer of the creative activities to patient care was discerned. How other disciplines, patients and the organisation could be involved in care delivery innovation was articulated.

Implications for practice:

- Practitioners demonstrate how arts-informed narrative inquiry can be used to construct knowledge and relationships to support practice development
- Practitioners are guided to be more response-able, rather than reactive, to organisational change
- Frontline practitioners are a necessary resource for the implementation and practice of a relational care delivery system and person-centred care that includes the personhood of the nurse

Keywords: Arts-informed, narrative inquiry, practice development, mental health, experience

Introduction

Our arts-informed narrative inquiry research programme in mental health dovetails with the practice development movement that has achieved international recognition and implementation (Eldridge, 2011; Andvig and Biong, 2014; Taylor et al., 2014). Practice development has been defined as ‘a complex intervention that integrates the systematic development of practice with empowerment of practitioners and cultural change that sustains specific outcomes’ (Manley et al., 2014, p 3). As nurse-teacher-researchers, our work is grounded in Connelly and Clandinin’s narrative inquiry (1990) and Dewey’s philosophy of experience (1938), through the three-dimensional space of sociality (personal-social), temporality (past-present-future) and place (landscape). Recently we conducted two related studies using arts-informed narrative inquiry. In the first, we partnered with students and nurses in mental health and in the second with a group of mental health nurses who are innovating a new care delivery model, relationship-based care. The two studies were methodologically connected, with two different populations of participants. Consequently, this article begins by summarising the first study before describing the second one, which illuminates professional development and person-centred care with nurses implementing relationship-based care in mental health. Our methodology is one way to enhance practitioners’ awareness and attend to the social climate of the professional setting.

In our earlier inquiry into how students and nurses conceptualise and enact person-centred care in mental health education and practice (Schwind et al., 2014), we undertook an arts-informed narrative inquiry in the academic year of 2012-13. This research was funded by the Associated Medical Services Call to Caring Phoenix Project in a partnership between two universities, a community college and a tertiary care mental health centre. Associated Medical Services (AMS) is an interdisciplinary organisation committed to person-centred care in practice and education. It defines person-centred care as, ‘high-quality healthcare that respects an individual’s preferences, needs and values, and is provided in an empathetic and compassionate way’ (Associated Medical Services, 2012, p 1).

In our previous inquiry, we conceptualised person-centred care as a relationship that prevents de-conditioning of people in our care, and we understood chronic (mental) illness to be a biographical disruption (Williams, 2000; Gillis and MacDonald, 2005; Lindsay, 2008a; Schwind et al., 2014). We explicitly moved beyond patient-centred care that focuses solely on the ‘other’ or the environment (McCormack and McCance, 2006; Ruddick, 2010; Fredericks et al., 2012). Our understanding of personhood includes the autobiography of the nurse and student nurse, as well as the patient. Within the research process of five meetings in person, nurses articulated their understanding of person-centred care and how they navigate the environment, institutional policies and interprofessional team relationships in order to implement it. The nurses told stories of how their agency is socially mediated within the complex institutional dynamics. Students, on the other hand, transitioned from defining patient-focused care in a way that excludes the practitioner to one that is relational and mutually informed.

Our current research, funded by the Centre Foundation, was conducted in 2013-14. We were interested in exploring how person-centred care is constructed and enacted using arts-informed narrative inquiry within an organisationally mandated care delivery innovation called relationship-based care approach. This approach was implemented on pilot units, co-ordinated by nursing education and administration. The orientation materials provided to the nurses on the participating units furnished information on the background and the relationship-based care model. The guiding principles of relationship-based care emerge from Manthey’s (2006) work on primary care nursing, adapted for short-term patients, part-time nurses and nurses working 12-hour shifts. This approach is centred on the concept of caring. It focuses on the relationships between the nurse and the patient, as well as a caring and healing consciousness that is essential to the healing process (Mathes, 2011; Winsett and Hauck, 2011). Relationship-based care has three inter-related concepts: relationship with self, with others, and with patients. In a similar fashion, practice development is ‘enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and

practice wisdom' (Manley et al., 2011, p 2). Our inquiry focused on relationship with self, using our concept of person-centred care, which illuminates what nurses bring to relationships with patients, other practitioners and the organisation.

Method

To conduct our current study, we used arts-informed narrative inquiry, which is a qualitative research approach that builds on Dewey's (1938) notion: experience is education. Narrative inquiry (Connelly and Clandinin 1990; 2006) explores selected phenomena over time, focusing on particular people in specific situations. According to these scholars, narrative inquiry investigates the multiple layers of experience for its potential for learning and for personal and professional development, suggesting that who we are as persons is who we are as professionals (Lindsay, 2008b). Understanding that eliciting and exploring personal experiences can be augmented through creative self-expression (Schwind, 2003; 2008), we developed a series of creative activities, which we further elucidate in this article.

We obtained research ethics board approval at our two universities and at the tertiary care mental health centre. To recruit participants, we created an invitational email and flyer, which were circulated by the programme director through the centre's intranet to nurses on the pilot relationship-based care units. Four nurses volunteered to take part in the research, which is appropriate for the number of participants within the narrative inquiry methodology. The arts-informed narrative inquiry approach was further refined to include three group meetings in person and two independent sessions with online resources. Alongside this inquiry, we developed a repertoire of reflective activities, in the form of a not-for-profit website (Lindsay and Schwind, 2014) partially funded by AMS, that can be used by all practitioners. The intent of this website is to provide global access to the arts-informed narrative inquiry activities for professionals in disciplines where development of self-awareness and personal knowing are of significance, and where development of the practice environment is desired. We piloted the materials for the two independent sessions with participants in the current study.

The first, third and last of the five sessions were held in person in a conference room at the centre. Each of these included check-in, a creative activity and group reflective dialogue. Sessions two and four were completed individually and at the convenience of the participants. Both of these sessions were supported by online video and written text instructions, with additional resources, so participants could independently complete the activities.

At our first meeting, participants were given a journal and a small set of coloured pencils to use throughout the research process (Figure 1). The first session involved participants defining person-centred care as they understood it at the start of the creative process. They then completed a lifeline exercise, wrote stories of giving and receiving person-centred care, and finished the session by affirming or refining their definition of person-centred care, based on their involvement in the creative activities. Participants began this work individually and then shared it, to the level of their comfort, with another group member. We completed this first session with a whole-group reflective dialogue.

In the second session, participants undertook a metaphoric reflection in which they reflected on their experiences of person-centred care with the relationship-based care approach, expressing these in the forms of images, letters and poems. As this session was completed independently, participants were invited to engage in the narrative reflective process (Schwind, 2008; 2009) with online resources, and to bring their creative self-expressions and journal writings to our next meeting.

Figure 1: Materials for creative activities



The third session began with participants sharing their metaphoric reflections and artistic creations. They were then invited to explore person-centred care in a social context. We invited participants to use art supplies and materials from magazines to create a collage on a large poster paper to illustrate how they locate themselves related to person-centred care in the context of relationship-based care approach. Each person presented their creation to the group and we took photographs of the collages.

Embodiment of person-centred care was the focus of the fourth session. Participants were invited to use movement and sensory awareness through a walking meditation, followed by colouring a mandala – one they drew themselves or accessed online. They were asked to bring these to the next group meeting.

Our fifth, and final meeting allowed for deepening of inquiry through music and drawing-in-relationship (Mantas and Di Rezze, 2011; Schwind and Mantas, 2012). For this creative activity, each participant wrote on a large poster paper a question they had about person-centred care within the relationship-based care approach, without revealing it to the rest of the group. After turning the paper over, they were asked to mindfully move pencil crayons across the paper while listening to music. We played Johnston and Shippey's (1998) compact disc *On Wings of Song*. Every three minutes, each person moved one place to their right, while continuing to listen to music and draw on the paper in front of them. The exercise was complete once participants were back to their own art paper. At this point, we asked them to contemplate their question in the light of the co-created artwork on their respective poster papers, and share their experience with the group.

The last activity of the five-session process involved each participant writing themselves a letter about person-centred care within the relationship-based care approach and what it meant to them after having engaged in this inquiry.

Findings

Our participants, as practitioners active in the implementation of person-centred care within a relationship-based care approach, returned to their experiences of caring for people in the setting. Participants defined relationship-based care as *'the heartbeat of the person'*, *'respect for self, co-staff and patients'*, *'cohesive team relationships'* and *'facilitates patient recovery'*. The nurses elaborated on

their definitions by saying that it was *'holistic and individualised'*, requiring an ability to *'relate with warmth'*, and to *'focus on the person and not on tasks'*. They observed that relationship-based care results in more horizontal relationships than the traditional vertical structure of primary nursing care delivery. We note that the nurses included in their definitions all the aspects of relationship-based care, namely, relationship with self, with healthcare team and with patients.

Our findings include participant stories that arose from completing a creative activity related to the experience of offering person-centred care in the context of a relationship-based care approach. At our first session, Sophia prefaced her story of offering person-centred care by saying:

'I just go inside and start imagining them as a newborn infant, precious to somebody, or conversely, not precious to anybody.'

Precious to somebody

This was a client on our unit a couple of years ago – a lady, brassy-blonde, dry hair pulled awkwardly back into a ponytail. She sat slumped, shoulders bowed with grief and agony, as men and women moved about her. I was pressed for time, documents not yet completed, my stomach grumbling with hunger. I saw the tear, it rolled slowly, sparkling down the curve of a rouged cheek, and it caught, winking, begging me to look into its depths. I stopped, because my feet stopped me. I sat, I was silent. I heard the whimper: 'He hated me all my life, oh daddy!' And the softest roar I had ever heard tore from her heart, and mine broke. My hand hovered over hers; she lifted her fingers and curled them fearfully over mine. 'I was adopted, they hated me, he raped me. My real parents don't want to reconnect with me.' And I saw her thin hand, soiled nails with chipped polish. I saw in it a tiny, soft, newborn beauty reaching up and meeting only cold empty air. The toddler, hurt confused. The fearful child. The angry teenager. The abusive mother. The broken patient. I couldn't find the words, and I couldn't find any words, but I was full of them. Then the words came out, uncensored, and I whispered, 'I would have been proud to have had a daughter just like you'. Silence. The tear dropped and was gone. 'Really?' she whispered. 'Really?'

In the second session, participants identified metaphors for offering and receiving person-centred care within a relationship-based care approach. Susie envisioned providing person-centred care as a lock and key, where nurses and patients can be either the key or the lock. Neither is fixed in role or contribution to the relationship. Participants discussed their awareness that each of them worked differently with patients and that uniqueness is honoured in the daily patient assignments. Some days, one approach would work with a patient, and on another it wouldn't, requiring nurses to negotiate who would be the best individual to provide care to that patient that day. Wendy shared her metaphor for receiving person-centred care as a garden with three blooming flowers:

'One needs a little extra care to become as strong as the others. And that's kind of how I viewed myself when I got hurt at work; I just needed help to become as strong as the other nurses on the floor. The flower needs water and when you are at a low point in your life, sometimes you just need someone to talk to. And that's what providing individualised care is in this metaphor.'

The final activity completed in the second session, and reported in the third, was a poem based on the narrative reflective process. Wendy's metaphor wrote her the following letter:

*'Dear Wendy,
Sometimes in life we have to share our burdens. Sometimes being vulnerable is not a weakness, but an opportunity to heal. Put your trust in the people around you. Everyone in your life is there in the moment for a reason. Take a leap of faith and let go of your need for control.
Love,
Metaphor for receiving person-centred care.'*

Mary offered the metaphor of a flashlight for providing person-centred care. *'Like a guiding light, showing the steps, because darkness is different for everybody. But everyone is going to have their own path and you need the team on the other side to hold the light.'* Mary's poem reads:

*'A guiding light that shows the way
Starts as a seed that grows with a nurtured need
We may not know we need it
But, as we grow strong,
We know we have received it
A gentle guide to the path that could not see,
A path suggested by seeing what makes up Me.'*

In the third session, which included collage making, participants 'moved from intuitions and feelings to thoughts and ideas' (Butler-Kisber, 2008, p 269). In sharing her collage, Wendy explained the thinking behind her illustration (Figure 2):

'I put the people in the middle. I tried to find diverse people, because our people are all very diverse. And then I tried to find words in the magazines that we addressed on a regular basis, things that might be important to them. And on the outside I have all these various little bugs and stuff, and that's us. We're the team working together. And there's no making me out different than anyone else, because I think we're all part of the team and we all mesh. At the bottom here it says "we are all here to remind you of the gift you are to others". And I think our people, especially our chronic sick people, kind of lose that. I think they have a loss of self, they feel worthless. You know, like they're just a burden. But everyone is a gift to someone.'

Figure 2: Collages: from intuitions and feelings to thoughts and ideas



Reflecting on the walking meditation completed in the fourth session, our participants commented on the usual racing pace they feel inside themselves and experience in daily life. They also spoke about their consciousness of time passing and being mindful of choosing a place to walk. They felt that a slowing down of their pace creates space for reflection on moments that might otherwise be missed.

Susie noted:

'It was more difficult than I thought it would be to turn my mind off of external thoughts. I didn't realise how much my mind is running all the time. It brought a whole new level of self-awareness to me. I found that becoming self-aware of the fact that I can't turn my mind off was just another step of becoming person-centred for myself. And that, as we know, is a key part of patient-centred care, having a good self-awareness.'

Mary added:

'I was on the streets, but didn't feel like walking there in case neighbours were watching. I changed course halfway through and went to a ravine. I prefer walking in the forest where there are no people.'

Sophia offered her experience:

'Walking slowly felt like too much time was passing at first. It's hard to push thoughts away. I was aware of birds, and the tires swooshing by on the pavement, and the wind soughing in the branches. There was an ant going home after a long day of constructing tunnels. He was mindful of only his existence even though the work was immense compared to him.'

Wendy searched the web for mandala images (Figure 3). She thought that the chosen picture was all leaves, but when she started colouring, she realised:

'There are little women beside the leaves. When you first look at it, everything is black and white and kind of looks the same. It's like with our patients – look under the leaf, to see their uniqueness.'

Figure 3: Mandala: a process of discovery



Moving from colouring to writing in a journal, Sophia reflected:

'I found something interesting when I was colouring. If the pencil came off the paper in a light shade, it annoyed me and I wanted to have it all uniform. Which made me start thinking: why is it bothering you? Why can't some areas be light and some dark? Why does it have to be all uniform? So, that's kind of interesting because, with patients, as we know, they're not all uniform.'

In the final session, participants shared their questions about person-centred care within a relationship-based care approach. Susie's question was: *'What more can we do to enhance person centred care for units that are just being introduced to it?'* Reflecting on the drawing, she shared:

'The way the music changed and influenced four people to draw differently allows me to draw correlations to person-centred care: individual journey, experiencing ups and downs in the music, and reacting in their own way. And then I underlined "reacting in their own way" because that sparked an additional thought. And I wrote "new units have to react in their own way; their own environment has to work for them". And that was what I took away from this. Every unit is probably going to look a little different, implement it a little differently.'

Sophia deepened her understanding by thinking out loud about her own co-created art piece:

'How can I, or can I, continue to balance caring and empathy within a professional relationship and not fade away myself day after day, month after month, year after year? So what I pulled out of this was: eat healthy, cry if you need to, exercise, jump and run; be renewed spiritually like perennial flowers that come up year after year, from the same core seeds of your humanity, of your selfness. When all else fails, just love. Just stay connected in community, with other professionals, with your family, your friends to ground yourself. Enjoy the arts, give yourself an outlet, sing and listen to music. Every single sketch [in our group] jumped out at me with a meaning. Keep yourself fresh and balanced to be able to continually give in person-centred care.'

These results, exemplified through our participants' creative expressions and words, demonstrate not only their values about who they are as nurses, but also their, and our, learning about what it means to provide person-centred care within the relationship-based care context of mental health practice. This learning is explicated in the following section.

Implications for practice

Our participants shared how they came into nursing, and into mental health nursing, through connections to experiences with family and friends. These narrative plotlines included: being the elder sibling, having relatives with mental health challenges, having issues with self-disclosure and identifying with patient stories. We wanted to understand how nurses include themselves in constructing their praxis with patients within a given organisational context. An interesting research tension for us was that we were not evaluating a care delivery system or its implementation. We engaged with the nurses in reflective practice that revealed their conceptualisation of person-centred care within relationship-based care as a practice development. Specifically, we were exploring 'relationship with self' that is intrinsic to the relationship-based care approach. In their final letters to themselves about their learning, our participants repeatedly mentioned that everyone (nurses, patients, other practitioners) is an individual, with aspects of uniqueness, readiness and knowledge that must be accounted for in building relationships. As Sophia said:

'I am one of the 'people', I need to listen. Person-centred care is staying really quiet, letting them breathe, walk, feel; don't interpret for them but offer options.'

This study demonstrates the need to consider the whole person. One way to access this is through creative self-expression to illuminate the relational connections between nurses, patients and others.

Our participants posed questions that may be a template for others to reflect on their practice to ensure person-centred care:

- How did I become a nurse?
- How did I come into mental health practice and for what purpose?
- What am I going to do here today?
- What am I going to leave here?
- How am I going to affect change in partnership with the patients?
- 'It is an honour and a responsibility to translate relationship onto paper.' How does documentation capture person-centred care within relationship-based care?

Participants linked self-care to self-awareness practices. Mary said:

'If you are having a hard time finding peace and happiness within yourself, then it's hard to care for others and radiate that peace and happiness to them. So, you have to make sure you take care of yourself. It's not just about eating well!'

Additionally, Sophia reflected:

A lot of [patients] pour out things to you that you would never hear from a family member or even a best friend. What to do with that and how to balance it? And then I realised how important I/the nurse really is. And it was like... people would say to me, how can you always listen to that? Or, isn't that really depressing? Well, it can be but the self-awareness, just be aware that we're all human.'

Self-care and self-awareness contribute to mindful presence with patients, helping nurses be more response-able rather than reactive. As demonstrated by our participants, this reflective work can be done individually or in small groups, at home or at work.

Another key narrative thread in this inquiry is temporality and ethical commitments. Our participants talked about knowing the patients over time, capturing the fragments of their life story. This allows nurses to see their patients as whole human beings in the context of a life, with mental health challenges, co-constructing the meaning of their experience and discerning options for living anew. Nurses do this in awareness of boundary issues, choices about self-disclosure and trustworthiness. This thread has implications for consistency of patient assignments and for how relationship building and meaning-making are facilitated through temporal considerations, which make space for learning through dialogue. We hope our scholarship changes the observation that in organisations, 'there is nearly no time built into the clinical routine for connectable human time with patients' (MacRae, 2010, p 289) or to learn from each other. Our participants saw this as the central focus of mental health nursing.

As participants recognised through this inquiry process, nurses and patients are in relationship in relationship-based care. They wondered how patients could be more actively involved in the care delivery approach. As one nurse observed, 'It really comes down to they [the patients] are directing it' by their voluntary participation in the milieu and activities. This key realisation challenges practitioner notions about control and organisational structure. It parallels the important observation that we have to move beyond being paternalistic (Cavanaugh, 2014) or only informative, and instead be interpretive, asking: 'What is most important to you? What are your worries?' (Gawande, 2014, p 201). By 'interpretive', we mean that practitioners are in partnership with patients. Patients are experts in their lives and practitioners have clinical expertise that works best if offered in the context of a specific patient's life. It is a negotiation of shared expertise that leads to further questions: how can patients be actively involved in care delivery innovations as experts? How can patients author their own lives? Finally, our nurses reflected that the creative inquiry activities could be completed with peers on their units. They note that it is different for members of the interdisciplinary team who may be an individual practitioner, such as a social worker or a dietitian, versus the multiple persons in a nurse or physician

team. They also suggested that the activities could be undertaken with patients, especially those who are non-verbal or withdrawn, as the art engages people in diverse ways. For example, Mary suggested that mandalas could be used in patient groups as a point of entry into dialogue. Sophia offered a mandala to a patient who talked about the process of her art and so reconstructed her experience in new ways for new understandings.

As our findings demonstrate, arts-informed narrative inquiry can be used to reconstruct experience to learn about self within the organisational context. Individual and group reflection helped deepen this discovery process and professional development. The nature of the activities facilitated creative questions and the understanding of how nurses shape and are shaped by the organisation. Also of significance is the time required to engage in this creative process. Nurses spoke of the gift of time, which they normally would not have, to take part in such personally and professionally rich work. Engaging in arts-informed narrative inquiry allowed them to move from a purely cognitive focus to exploring person-centred care within a relationship-based care approach more holistically, thus increasing the depth and the breadth of possible futures for self, others and the organisation.

Concluding comments

Practice development, facilitated by arts-informed narrative inquiry, affirms the personhood and uniqueness of nurse and patient in relationship. Nurses' awareness of their narrative patterns and what they discern is needed in a situation of relationship-based care is heightened. Through arts-informed narrative inquiry, the nurses became more aware of how to advocate for themselves and for their patients. They also pondered how they shape and are shaped by the organisational context.

If narrative inquiry is working, readers are drawn into their own practice and may want to consider the following questions:

- What are the connections between your personal experience and your professional practice?
- How does your healthcare organisation support (or not) engagement of practitioners within person-centred care?
- How could you implement arts-informed narrative inquiry with colleagues and patients to enhance practice development within your organisation?

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Acknowledgements

We are grateful to the Ontario Shores Centre for Mental Health Sciences Foundation, Whitby, Ontario, Canada and Ryerson University, Faculty of Community Services Dean's Fund, Toronto, Ontario, Canada, for funding this study.

We also wish to express our sincere appreciation for the contributions of our research team members, who facilitated the organisational processes that supported this study: Dr. Sue Coffey, Associate Professor, University of Ontario Institute of Technology; Cathy Duivesteyn, Clinical Educator, Professional Practice; Sanaz Riahi, Director, Professional Practice; Dr. Barb Mildon, Vice-President, Professional Practice and Research/Chief Nurse; and Bobbie Ivankovic, Clinical Manager, all of Ontario Shores Centre for Mental Health Sciences.

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