The power of diversional therapy: employing co-creation as a process to design a culturally responsive mural using the kawa model.

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Abstract

Background:
To describe a diversional therapy project completed within an adult forensic mental health unit in regional Australia.

Method:
The mural diversional therapy project planning, co-design process and implementation are described. Reflection on identified outcomes are discussed.

Results:
A small cohort of adult forensic mental health consumers participated in a group diversional therapy program involving the co-creation of a wall mural. The co-design process involved collaborative input from unit mental health consumers, the unit's Occupational Therapist and the Advanced Recreational Officer. The resulting mural design integrated elements of the Kawa Model into a culturally responsive mural design. Mental health consumers' participating in the project identified themes such as experiencing a sense of pride, achievement, connection, relaxation and ownership. It is anticipated that the mural's embedded visual symbolism and cultural responsiveness may provide consumers with ongoing therapeutic outcomes.

Conclusions:
Mural diversional therapy had positive effects on adult forensic mental health consumers. Embedding Kawa Model metaphoric symbolism into the mural design using a co-design approach adds a therapeutic legacy for future forensic mental health consumers, which has relevance for adult psychiatric inpatient care.

Key Words:
Co-creation, mural, forensic mental health, Kawa Model

Background

From the 1930s onward, psychotherapists and arts practitioners have posited that non-language-based forms of visual self-expression possess benefits for people with mental health problems (George & Kasinathan, 2015, p. 49). An emergent evidence base supporting this view from claims made by art therapy, community arts and health organisations, mental health consumers, artists and mental health care practitioners that mental health consumers who participate in arts-based programs can better express their lived experience of illness, enjoy greater social inclusion and experience improved mental health recovery (Parr, 2006; Howells & Zelnick, 2009, p. 221). Current literature within the *arts and health* field with a focus on arts-based therapeutic interventions in mental health can be divided into two broad categories. One category includes studies that identify arts-based approaches used in non-clinical settings eg. participatory or community arts (Jensen A & Bonde L, 2018; Power, 2018), and the second includes studies of art therapy within clinical settings (Van Lith, 2016; Goodman-Casanova et al. 2023). Findings from both literature sets suggest 'positive and reliable psychological effects' for consumers of mental health services with a 'range of diagnosed illnesses' (Jensen & Bonde, 2018, p. 2).

A recent systematic review of interventions initiated by creative art therapists and other arts and health professionals across a wide range of modalities suggests five common mechanisms of change that promoted positive changes in mental health symptomatology. These mechanisms include physical (e.g., neurochemical effects), intra-personal (e.g., enhanced self-concept and agency; processing and communication of emotions), cultural (e.g., creative expression, aesthetic pleasure), cognitive (e.g., stimulation of memory), and social (e.g., increased social skills and connection) (Dunphy et al, 2019, p, 1). Likewise, a comparative summary of claims by community arts-based interventions in mental health suggests that generative mechanisms such as positive affect of feelings of wellbeing, improvements in self-expression and mental health, enhanced physical health, cognitive stimulation and improvements in attention and memory, increased social connectedness and sense of belonging, and access and connection to culture (Power, 2018, p. 23-27). Interestingly, both literature sets claim similar or interrelated mechanisms of change.

While searching across these two broad literature sets, few studies describe arts-based diversional therapy approaches used in long term mental health consumer recreational programs. Little evidence currently exists that identifies and describes the processes used in arts-based psychosocial interventions involving long-term forensic mental health consumers. This paper will describe the co-creation process used to create a wall mural in forensic mental health unit in regional Australia.

Psychosocial interventions

Findings from Jensen and Bonde's (2018) literature review of the use of arts interventions for mental health and wellbeing in clinical settings suggests that arts-based programs that provide meaningful creative activity can promote and nurture psychosocial resources. These psychosocial resources include the redirection of focus toward optimistic life experiences which improve self-esteem, promote active coping skills, boost identity building and ability to enlist social supports (Jensen & Bonde, 2018; Raynolds & Lim, 2007). While improvements to the wellbeing of participants with mental health problems was evident, it must be noted that larger, longitudinal studies are required to establish greater research rigor and understanding of longer-term effects (Jensen & Bonde, 2018, p. 4; Dunphy et al, 2019). From the growing research evidence identified in *arts and health* literature, arts-based activities provide mental health consumers with a 'holistic, low cost, and non-medical interventions' with the potential to improve wellbeing (Jensen & Bonde, 2018, p. 5; Power, 2018). The mural project described in this paper highlights the observed improvements to wellbeing noted among in-patient participants who took part in the co-creation process.

Co-creation process

Terms such as 'co-design', 'co-production' and 'co-creation' have been used to describe the development of initiatives or projects that involve the participation of multiple stakeholders in a shared project outcome (Vargas et al. 2022, p. 1). These terms have more recently evolved from the broader concept of Participatory Action Research and its specific methods (Vargas et al., 2022). While these terms are often used interchangeably, co-creation is viewed as an 'overarching guiding principle encompassing co-design and co-production' (Vargas et al., 2022, p. 1). The co-creation process 'promotes the creation of value' by bringing together stakeholders to understand complex problems, and design and assess solutions that work within that context (Vargas et al., 2022, p. 2). Currently, consensus on whether co-creation is an approach, or a method remains an unanswered question (Szebeko, 2010).

However, De Koning et al. (2016, p. 273) *Steps of Co-creation*, seen in Figure 1, provides a framework in which to describe the multiple steps in the co-creation process and make sense of its iterative nature. The six steps of De Koning et al.'s 2016 model involve the interrelated concepts of identifying, analysing, defining,

designing, realizing, and evaluating or reflecting on phenomena, in this instance, the creation of a mural.

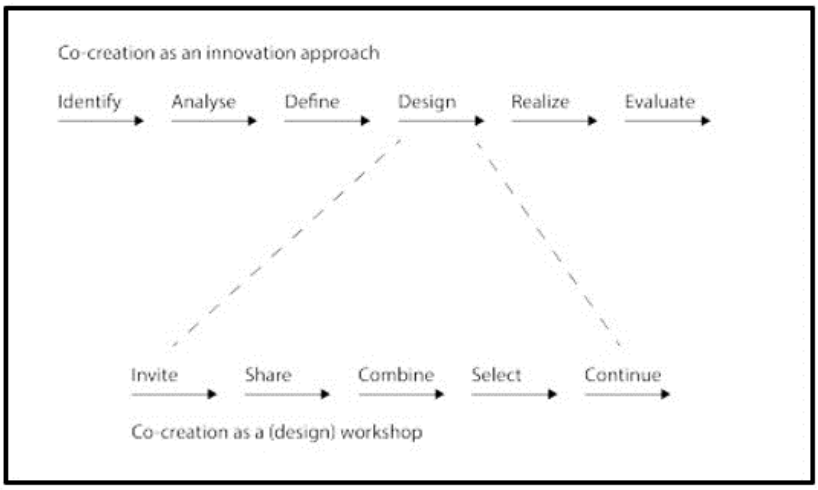

Figure 1 The Steps in the Co-Creation Process (De Koning et al., 2016, p.273)

The paper will use the term co-creation to describe the active collaborative approach used between stakeholders, in this case forensic mental health consumers, occupational therapists and advanced recreational officer, in the design and creation of a wall mural in a forensic mental health unit. By describing the co-creation process used, the paper aims to explore the approach used, the possible change mechanisms at play within the mural project's co-creation process (Vargas et al., 2022, p. 2) and describe the utilization of the Kawa Model to develop mural imagery for therapeutic purposes.

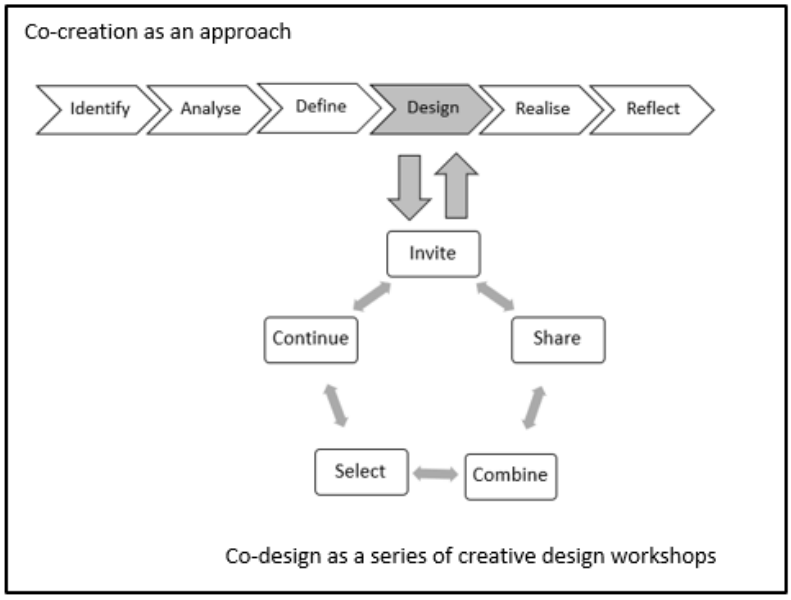

Figure 2 Steps to Mural Co-creation Process

The steps used in the mural co-creation process follow the majority of De Koning et al. (2016, p. 273) stepped process, however the final step of De Koning et al. has been modified to better represent the co-creation process used with consumers. The term "analyse', used in De Koning's Figure 1 model, has been substituted for the term "reflect". This change in terminology reveals the way stakeholders, including consumers, Advanced Recreational Officer (ARO) and Occupational Therapist (OT), discussed and considered design changes during and after the creation and realization of the mural. In addition to this change, the co-design process used to create the initial mural design used a series of design workshops that were non-linear in that they started at one spot and finished at another like the process described in De Koning et al. 2016 model. The mural workshops instead used an iterative process that involved a cyclical process which refined the latest version of the design ideas to make a subsequent rendering of the design. The co-design process, while iterative in nature is also shown to move in a forward and reverse direction depending on the views and subsequent decisions of the stakeholders (see Figure 2). The integration of the Kawa model into the development of the mural occurred within this design step is a good example of this iterative process.

Kawa Model

The Kawa model was developed by Michael Iwama in early 2000s in response to the cultural context in which he was practicing (Turpin & Iwama, 2011, p. 159). The Kawa model uses the visualization of a 'river' and its elemental parts as a metaphor to represent 'life flow or energy' (Turpin & Iwama, 2011, p. 160). The river and its elements are used to describe the history of an individual, family or organisation, with each element, the river floor and walls, rocks, and driftwood, representative of personal circumstances (Iwama, 2006). The river water flows through the elements which can increase of decrease the river flow. Change can occur in the size, shape and location of the elements which subsequently alters the river flow (Turpin & Iwama, 2011, p. 160). The possibility of change underscores the reasoning behind occupational therapy recovery interventions. The Kawa model as an intervention which nurtures components of recovery in a way that is person-centered and culturally responsive (Gregg et al., 2015, p. 368).

The integration of the Kawa model through the co-creative process was determined on the basis that this model can be applied in a psychosocial context that embraces dimensions of culture like shared values, attitudes, beliefs, language and symbols in a holistic way from an individual and collective perspective (Gregg et al., 2015, p. 369). The innovative use of the Kawa model within the context of mural project described in this paper provides a clear example of the Kawa model's potential for cultural inclusivity and adaptability.

Method

Setting

The mural project was set in a 30 bed, adult mental health unit providing psychiatric rehabilitation care to forensic patients, within a psychiatric hospital situated in regional Australia.

Participants

The mural project participants who worked directly with others in the co-design and painting included 15 consumers, all male, with ages ranging from 20 to 58 years. Over half identify as First Nations people and have a varied diagnosis of mental illness. Over the ten months the project operated, 2 new patients were admitted to the unit during the project's life cycle. During the project 2 of the participants were discharged out of the unit and 4 more were in various stages of transitioning to community settings. Of the original 15 consumer participants 9 remain as patients within the unit post project completion.

Procedure

The ARO from the Rehabilitation and Recovery team attached to the hospital was both the project's lead and facilitator. All unit mental health consumers were encouraged to take part in the mural project at morning meetings within the unit. The ARO provided two, 3-hour sessions, per fortnight over a 11-month period from January to November 2023. Each of the weekly sessions operated using a psychosocial framework. During the painting of the mural participants had to have the correct leave conditions to work on the mural which is situated outside of the unit. Consumers who didn't have leave were able to watch the painting of the mural from inside the unit.

The co-creation process used in the mural project utilizes the six steps found in model De Koning et al. (2016) model shown in Figure 1 that were subsequently adapted to the unit setting. The six interrelated steps used in the mural co-design process, illustrated in Figure 2, include identifying, analysing, defining, designing, realizing and reflecting used in the development of the mural are detailed in the paper along with the outcomes from a collaboration with occupational therapy used to embed the Kawa model within the imagery of the mural.

Results

Co-creation process

Identify

In this stage of the co-creation process, the ARO set about identifying the 'value created' through the process of bringing together stakeholders, consumers, allied

health and nursing staff, to understand the creative project at hand, and design and paint the mural within that context of the unit. The aims of the mural project were three-fold:

- to engage adult forensic mental health consumers, allied health practitioners and nursing staff together in a collaborative psychosocial activity that utilised a co-creation process to complete the mural.
- to involve the consumers in a longer-term art-based project that are culturally responsive, improved the unit's aesthetic environment while enhancing consumer wellbeing; and
- to add value to the mural by embedding metaphoric imagery derived from the Kawa model that can used with current and future consumers as a therapeutic assessment tool by occupational therapists.

Analyse and Define

Once the mural project's aims were identified, the next step was to tease up components of the project planning, examine the mural site and define how to best communicate and engage with stakeholders. Planning for the mural project required a Risk Management Plan and the support from the Nurse Unit Manager and Director of Nursing at the hospital. The site of the mural was outside of the secured fenced area around the unit on a retaining wall that encircles half of the unit buildings. The cement block retaining wall, which was approximately 2.20 m high and 14 m long, required cleaning before painting of the mural could begin. The retaining wall site was strategically chosen by the ARO to maximise consumer's view of the mural so that they could see the mural from the unit's communal space.

The ARO who has experience in co-designing and facilitating community mural projects worked with participants to create a safe space where all opinions and ideas were respected and heard. Within the safe group space, participants could engage with the workshop at a level that best suited their needs and ability to concentrate. By providing a flexible safe group space, participants could be directly engaged in the activities or watch and at times both, easing any anxiety or stress they may feel within a group situation.

Cultural responsiveness and representation were key considerations underpinning the mural co-design. The unit's population at that time could be described as having a high proportion of First nations people. Therefore, recognizing, celebrating and responding to the shared cultural identity of consumers was a key design component.

Design

The design step within the co-creation process involves the five, often iterative, phases that include, inviting, sharing, combining, selecting and continuing. The mural project used each of these five phases to arrive at workable design concept. The

process used to arrive at a workable design, one that is still subject to changes, was not linear and at times looped back when design issues or further ideas were incorporated. The co-design of the mural began in February 2023 and continued until May 2023.

The ARO and the unit's activity nurse first discussed the mural project idea with consumers at their regular morning meeting and **invited** consumers, as key stakeholders, to take part in the project. Consumers who were interested in the project formed a breakout participant group. During this initial meeting the ARO outlined the scope of the mural project to the participants and showed them photographs of the mural site.

In the initial stages of the co-design process the ARO presented participants with images of other murals from around their local area. Additional to this set of images, multiple photographs of Australian First Nations people mural artworks were viewed and discussed. The participants were encouraged to **share** their thoughts about the supplied set of mural images and how mural artists' used imagery, colour, and symbolism and what they felt the imagery signified. Participants were then provided with drawing materials and collage materials so they could reproduce their ideas and share them with the group. First Nations people cultural symbols, imagery and stylistic mark making and painting technique ideas were incorporated into the designs produced by individual participants. An example of this is the use the First Nations people flag and the Sand Goanna identified as a First Nations family totem by a participant.

Once finished, participants shared images and their thoughts with the group. The images generated were then **combined** and developed further. The group agreed upon a **selection** of images and with the support of the ARO these images were translated into a preliminary, collective visual story, Figure 3.

At this stage in the co-design process, the ARO and the OT collaborated on ways that the initial design or visual story could be enhanced to enrich the value of the mural to include a therapeutic outcome. The formation of this collaboration created a learning loop, see Figure 2, in the co-creation process that added 'value' to the original visual story and established a therapeutic legacy for current and future unit consumers. The OT's idea of incorporating the Kawa model shifted the design step in the co-creation process by looping back to the invite, share and combine phases where elements of the Kawa model were combined with the original visual narrative. The OT and ARO's ideas took the original snake image that ran through the center of the design and translated it into the Kawa model's river metaphor, with its associated elements of water flow, riverbank, rocks and driftwood (Iwama, 2006). Incorporating this change into the design aligned with the projects aim of creating a mural that was culturally responsive and collaborative.

These new ideas were taken back to the unit's participant group where the group **shared** their opinions of the proposed changes where further refinements where **combined** and **selected**. Some of the participant group found this inclusion of ideas difficult to understand, however with further discussion and negotiation of the proposed changes the group agreed on the changes and the design moved into the **continuing** phase where a final visualization of the mural design was developed.

Figure 3 Illustration of collective visual story

A key line drawing mapping the mural in its entirety was created by the ARO with the assistance of participants. Once completed, sections of the key line drawing were used by the participants to explore and decide upon the use of colour. At this point in the design step of the co-creation process, a fully illustrated version of the mural was created by ARO and participants. To garner support for the next step of the process, a laminated photocopy of the mural illustration was hung in the unit as a way of promoting the project and eliciting help with its painting. Throughout the design step an increase in conversations among unit stakeholders such as consumers, nursing and Allied Health staff and outside community members was created around the project and its objectives. The mural provided a positive topic for the unit's stakeholders could engage with or share an opinion of, outside of notions and conversations of hospitalisation and mental health.

While the design process was still being worked through the ARO was working in the background to complete the safety planning, the purchase of painting materials and the preparation of the project site. Where possible project participants were involved in discussions about paint colour choice, ordering and purchasing of materials.

Realise

Now that the mural design was finalized, the next step in the co-creation process was the realisation or painting of the mural. To finally realise the mural project, project participants were required to engage in the preparation, drafting and painting of the chosen design onto the designated site. Participants in this step of the process needed to have appropriate leave conditions to move beyond the unit's secure boundaries to work on the mural site.

In late May 2023, the cement block retaining wall used for the site of the mural was cleaned by hospital maintenance and participants assisted in the undercoating of the

wall surface. Next the participants assisted the ARO to grid up the wall surface so that the outline of the mural design could be drafted onto the wall, see figure 4. The painting stage of the project which began in June 2023.

Figure 4 Grided mural outline on wall

To maximise the potential wellbeing outcomes of the mural project, the ARO integrated a celebration of the National Aborigines' and Islanders' Day Observance Committee (NAIDOC) into the unit's usual programmed mid-week BBQ. The NIADOC week event was also an opportunity to celebrate and promote the beginning of the painting phase of the project. The Indigenous Mental Health team was invited to lead the celebration with a smoking ceremony and other cultural activities. Involving the Indigenous Mental Health team at this point in the project helped reinforce the cultural responsiveness utilised in the mural imagery and to improve a sense of identity, belonging, and community among unit consumers. Multiple unit consumers expressed the 'enjoyment' they experienced while attending the BBQ celebration. Observation of consumer and project participants general wellbeing suggest positive feelings were experienced during the NAIDOC week celebration which had a spillover effect on how unit consumers appreciation of the mural.

During the painting of the mural maintaining a flexible approach to translating the illustrated design agreed upon by the stakeholders was an important aspect of the continuing realization of the project. Many design changes evolved over the realization step of the process which involved negotiation between stakeholders and a willingness to trial ideas put forward by the group to solve project challenges. An example of this flexible approach to problem solving and the importance of listening to stakeholder concerns presented itself when one of the unit's consumers was able to raise their concern about an aspect of the design, in this case, the eye colour of the owl who was a dominant character in the mural design. After listening to these concerns, the ARO discussed the issue with project participants. The group agreed that the eye colour be changed from red to yellow to alleviate any concerns that the consumer was experiencing while looking at the mural.

Throughout the six months it took to realise the painting of the mural image, the mural project and the symbolic imagery of the design become a topic for conversation shared between unit stakeholders. Observations of consumer interactions with the ARO, nursing staff, cleaners, support workers, family members and friends suggest that the developing mural provided avenues for the expression of opinions, ideas and a focus outside of consumers mental health diagnosis. Consumers and project participants alike were able to express their feelings of pride, sense of ownership and excitement with others outside of the unit by showing the mural to visiting family members and support workers as well as sharing photographs of themselves in front of the mural. During the painting of the mural participants working directly on the mural and consumers who were inside the unit boundary fence were able to listen to and share music while painting. The mural painting provided the ARO with multiple opportunities to check-in with consumers, develop stronger consumer relationships and discuss a wide range of topics relevant to consumers. Observations of these encounters with consumers suggest that the mural project become a nexus from which the unit stakeholders were able to improve their sense of community, connection and belonging.

To acknowledge their participation in the mural project, consumers placed their handprints on a chosen part of the mural, see Figure 5. Most chose sections of the mural that were meaningful to them so that when they looked upon the mural, they had a direct visual association that links their positive memories of participation and the shared experience of mural's co-creation. Each consumer that was agreeable had their photograph taken in front of the mural. The photograph also become a positive reminder of their personal and shared participation and reinforced their experience of achievement and success. Some consumers included these photographs in Christmas cards to family. By doing so, consumers received positive recognition from family members for their participation and achievement.

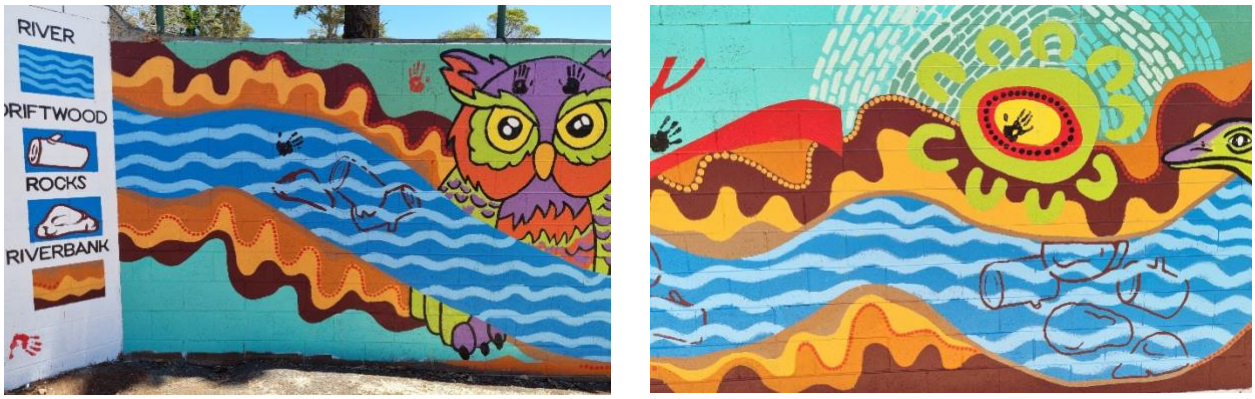

Figure 5 Handprints of consumers on mural

Evaluate

The final step in the co-creation process provided an opportunity for the project stakeholders to reflect on and evaluate the mural project and value created by it. To celebrate the success and assist in the evaluation of the mural project, the ARO created a PowerPoint slideshow of photographs detailing all the steps of the co-creation process. The slideshow was used as a debriefing tool to facilitate small group evaluation discussions with stakeholder groups such as unit nursing staff, consumers, and Allied Health staff. Feedback from small group evaluations suggests that the project was 'valuable', 'improved the visual environment of the unit' and 'improved wellbeing in the unit'.

The ARO also used the PowerPoint slideshow for one-on-one conversations with consumer participants. These conversations provided a space for participants to personally debrief, give feedback on the co-creation process and celebrate personal achievements and contributions to the project. Observations from these consumer debriefing meetings suggest that consumers evaluated the mural project highly and enjoyed the co-creation process from start to finish. Participants expressed their feelings of connection, belonging and wellbeing through their participation in, and contribution to the project. On a personal level, participants also expressed how they experienced a sense of personal achievement each time they view the finished mural.

Figure 6 Completed mural

Discussion and implications

Art interventions like the mural project described in this paper, provide meaningful activity for the psychiatric rehabilitation of adult forensic consumers in a regional setting. Participation in the mural project provided a creative vehicle in which to redirect their focus toward positive experiences that were observed to have improved their self-esteem, sense of identity and ability to mobilise social supports

(other unit stakeholders) and connection (Jensen & Bonde, 2018). Additionally, project participants were observed to have enhanced their overall wellbeing by increasing and nurturing their psychosocial resources (Jensen & Bonde, 2018; Raynolds & Lim, 2007). The finished mural transformed the visual environment of the unit and a created sense of ownership among consumers which improved consumer wellbeing (George & Kasinathan, 2015; Power, 2018).

Observations of possible change mechanisms present in consumer behaviour and mood throughout the project include: intra-personal improvements such as enhanced self-esteem, pride, feelings of accomplishment and the ability to express these feelings; cultural expression of First Nations identity, culture and aesthetic pleasure; cognitive mechanisms such as reminiscence, problem solving, increased attention and memory; and improved social connection through teamwork, sharing of music and discussion of ideas (Dunphy et al, 2019; Van Lith, 2016; Power, 2018).

The mural project had substantial limitations ascribable to its lack of research methodology, descriptive nature and contextualization within a regional, medium security forensic mental health unit (George & Kasinathan, 2015). The positive benefits observed by health service staff and reported by consumers are not able to be confirmed or replicated. Project participants varied throughout the 10-month project due to new consumer admissions, leave requirements and consumer transition back into the community. Project participants also varied in their psychiatric diagnosis and stage within their recovery trajectory.

However, the mural project demonstrated that co-creation is a viable and worthwhile process to use in this highly specialised clinical setting. The stepped co-creation process used throughout the design and painting of the mural, described in Figure 2, was seen to empower consumers and foster agency by permitting consumers to make design decisions and communicate ideas through the imagery chosen. The iterative or cyclic nature of the co-creation process allowed the mural to evolve as it was being realized through the painting process. As adjustments were made to the overall design other design decisions were necessary. Observations of positive improvements in consumer wellbeing and behaviour during the mural co-creation process has relevance for adult and adolescent forensic psychiatric rehabilitation units.

In addition to the positive consumer wellbeing, the utilization of metaphoric imagery derived from the Kawa model embedded within the mural has the potential to be developed into a therapeutic assessment tool for current and future unit consumers. The therapeutic legacy afforded by the mural is evident in the vastly improved aesthetic appeal of the unit environment and the shared metaphoric meanings and common understanding of objects (rocks) and phenomena (river flow) that is culturally responsive to both First Nations people and non-indigenous consumers.

Likewise, the innovative application of the Kawa model embedded within the mural imagery has implications for its application in adult and adolescent forensic psychiatric rehabilitation. The positive outcomes from the mural project greatly added to the recovery journey of consumers who experienced a sense of connectedness and empowerment.

The authors report there are no competing interests to declare.

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