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Effective mass line implementation of meditative practices to generate behavioural momentum toward self-regulation and symptom management in communities for persons with serious mental illness focused on supporting standards of mental health wellness and recovery[1]

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Abstract:
This observational and quantitative study examined the efficacy of using the mass line approach to define and implement a meditation program within a support community for a population with serious mental illness. During 2013, 156 sessions of 40 minutes each were conducted within the MCHA/OASIS community, a not-for-profit mental health recovery[2] support centre in Rhode Island. Participants were allowed to choose whether to attend all, part or none of the sessions throughout the duration of the program. Mass line analysis was used to change and refine the program according to the expressed needs of the community on a continuous basis while adhering to the centre's guidelines promoting mental health recovery and wellness. Findings suggest that the common assumption promoted by the US

[1] This study was done with the permission and assistance of the Mental Health Care Advocates of Rhode Island (MHCA/OASIS). This research was funded in part by MCHA/OASIS and through private contributions to Dragon Mountain Chan Temple and Zen Community Centre of Rhode Island for this purpose. All correspondence concerning this research should be addressed to Cassandra Tribe, 11 South Angell St #181, Providence, RI 02906. Contact: Cassandra@z-cc.com

[2]Substance Abuse and Mental Health Services Administration. "Recovery is a process of change through which individuals improve their health and

government through its website on complementary practices and accepted by the mainstream psychiatric and social welfare systems that the practice of meditation presents a risk or would be ineffective with a population with psychiatric illness is unfounded. It is also suggested that the majority opinion of the treatment community towards consumers regarding meditation practices is based on an erroneous understanding of the desired behavioural operant, the role of facilitators, and how to subsequently measure efficacy on an individual and communal scale. With the correct implementation of a meditation program using movement and seated meditation, the population was able to generate behaviour momentum guaranteeing positive reinforcement that promoted use of the techniques outside of the centre and session applications. Further detailed quantitative study of the effects on health, wellness and social capital are being done on the same population in regards to this program during the course of 2014.

Key words: behavioural momentum, mass line, positive reinforcement, serious mental illness, meditation, mental health recovery communities, self-regulation, symptom management

The use of movement and meditation within group recovery practices for persons with Serious Mental Illness (SMI) is a contentious practice in the United States[3]. Part of the struggle comes from the problems inherent to this community and the other stems from the lack of practical and traditional training in meditation by the facilitators and program designers. A recent year-long initiative introduced a traditional program of Chan meditation and movement to a community centre for those with Serious Mental Illness to examine the viability of movement and meditation in a population identified by Any Mental Illness. The hope was to gain a better understanding of

wellness, live a self-directed life, and strive to reach their full potential. " US Department of Health and Human Services. Rockville, MD. 2011.

[3] U.S. Department of Health and Human Services, National Institute of Health: National Centre for Complementary and Alternative Medicine.

the problems with meditation and Serious Mental Illness and to suggest what potential resolution could be.

One of the underlying suspected causes of the majority of problems associated with using meditation as a complementary or support practice with those with Serious Mental Illness stemmed from the inadequate training of the facilitators and program designers. It was not the result of anyone with a Serious Mental Illness being unable to manage their reaction to meditation. In examining why the training and programs were inadequate, the core problem was theorized to stem from the Westernization of traditional Chan practice to increase its accessibility to Western culture that then resulted in a dilution of its ability to be effective by making the current practices and mind-sets of facilitators too rigid to be able to respond to what is happening in the moment.

By further following the hypothesis it was surmised that applying the principle of the mass line theory[4] within this setting could provide a cost and time effective means to correct the approach of the facilitator and the design of the program to create a fluid and effective meditative practice that could be used by persons with Serious Mental Illness, as well as Any Mental Illness to provide for self-management of symptoms. It was also believed that by using the mass line results as a guiding tool a new program for training facilitators could be implanted to restore flexibility, presence, mindfulness, discipline and compassion to their education.

Identifying the roles in the setting

In turning to a traditionally trained resource, MHCARI/OASIS tried a year-long study in introducing daily movement and meditation to a community support centre for those living with Serious Mental Illness. The results were positive in the sense of

[4] Mao Tse-tung, Surplus Labour has found a way out," The Socialist Upsurge in China's countryside, Chinese ed., Vol. II. 1955.

proving the benefits of meditation for persons of all stages of mental health; however it has revealed both a dearth of appropriate training for CMI facilitators, and a growing gap in capabilities of facilitators coming out of Buddhist traditions as their programs and practices continue to be diluted to suit western and American culture. The reflection on the findings of the course study suggests that a reconsideration of meditation with those with Serious Mental Illness, and a reconsideration of how far cultural adaptation of traditional practices can go before they become ineffective are suggested.

It has been discussed at length by Master Sheng-yen[5] that the core Western misunderstanding of the purpose of meditative practice has served to limits its ability to be applied as a complementary therapy in communities such as these. The need to scientifically quantify an effect of meditation has led to a misinterpretation of the actual result of developed practice. The scientific quantification has focused on the physical reactions as most often measured by skin response tests and heart rate. In communities with mental illness where long-term medication has been common, the basal metabolic rate and metabolic predictability of the persons become impaired. Added into this is the newly recognized aging acceleration caused by depression and mental illness[6] and populations with mental illness will also have other physical ailments associated with demographics a decade or more years older than the chronological age of the community recorded with its attendant mobility issues, chronic problems and long term medication effects.

In defence of the need for a quantifiable and replicable result driving studies of metabolic reaction to meditation, there

[5] Master Sheng-yen and Dan Stevenson. Hoof prints of an Ox: Principles of the Chan Buddhist Path as taught by a Modern Chinese Master. Oxford University Press, USA. August 2002.

[6] Verhoeven et al. Major depressive disorder and accelerated cellular aging: results from a large psychiatric cohort study. Molecular Psychiatry, November 2013.

is a need for solid statistical surveys to show the efficacy of these programs as a means to complement support and therapies for those with Serious Mental Illness. There is a noted lack of any material showing a direct study of the implementation of adjunctive therapy and support through meditation in individuals and communities with mental illness due to the perception of the risk of meditation practices with certain disorders. The majority of the studies on the effects of meditation have been limited to qualitative self-reporting of the experience of a healthy group, medical imaging and quantitative studies of the effect of meditation on the brain on healthy people and the very limited experiential reports of psychiatric communities that have used forms of guided relaxation hypnosis inductions for select patients.

Hypothesis

Two forces are at work in the social welfare system that has prohibited meditation from being effectively introduced as a supporting or complementary therapy for those with Serious Mental Illness and Any Mental Illness. The first is the standard declaration by the U.S. Department of Health that has discouraged the use of meditative practices with mentally ill consumers because of a perceived risk of dissociation, disturbance and inducement of psychosis or delusions. The second comes from the adaptation of the traditional Chan practices to popular alternative culture within the American society that has reduced the focus of the practice to one of self-focus and individualized experience.[7] The lack of contextual study of the sutras, diligence in practice and the promotion of patient practice over a form of rapid achievement have allowed

[7] Fixsen, Naoom, Blase and Friedman. Implementation research: a synthesis of the literature. Tampa, Florida, University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network, 2005.

a diluted form of Buddhist practice to be embraced by the alternative culture. The unfortunate effect of going too far in adapting the traditional practice to a culture is that the meaning and effectiveness of the practice, with or without fidelity to the beliefs – has lost its ability to provide for a check for the mental stability, intent and methodology of the practitioners promoting it as a treatment for the reduction of stress and anxiety in those with mental disorders of any degree.

Rather than promote a more independent and freer interpretation of Buddhist practice and belief that leads to greater accessibility and application; the removal of discipline and structure has led to a preponderance of schools and practitioners that are more engaged with individualistic interpretations that cling to a kind of materialism and reject change, adaptability, flexibility and responsiveness as a value in community practice. The duality of sudden enlightenment and revelatory enlightenment of the Chan tradition has made it particularly susceptible to adoption by those who under less kind circumstances would be considered narcissistic seekers of a cult of personality.

Core to the identity of these practitioners is the presentation of meditation as having a specific goal, as well as all experiences and beliefs systems being but only differently voiced versions of the same universal experience. This individualistic and self-centred interpretation of traditional practice has gained a strong foothold in the Western world as it retains the individual as the centre of the essence of all cycles, removes the need for training and supervision, and establishes a role in which authority is not to be questioned or constructively criticized. When this is combined with the recent scientific studies of certain types of meditation that have quantitatively defined a physical effect for the practice – the result is the creation of a false behavioural operand that can only lead to failure, as well as harm when introduced to a marginalized and vulnerable community along with a complete

invalidation of the social capital of marginalized communities by refusing them the value of their unique identifiers.

This phenomenon is not unique to the religion of Buddhism. Unlike its companion trends in Christianity and Islam; the practices of the latter faiths are not being used by medicine and science in healthcare because they are culturally recognized as being religions only; while Buddhism suffers the perception of being more philosophy than faith. This has led to practices being adopted and taught out of context of experiential development and meaning.[8] Missing from the approach that is inconclusive of religious practice and context is a built in system of checks and balances to monitor the behaviour and the practices of the facilitator as well. Many programs that have tried to bring in meditation sessions for their consumers have been confronted with the reality that the majority of Certified Meditation Instructors (CMI) in the United States are ill prepared to handle the realities of working within a community of the seriously mentally ill.[9]

Anticipated participants represented a broad spectrum of mental illness, mobility and cognitive functioning level. The range of mental illness within the membership can come from managed clinical depression to adult psychosis and schizophrenia among others. The level and length of medication for each participant is also widely varied with some exhibiting Tardive dyskinesia, tremors, balance issues, cognitive functioning and problems with staying awake while others are barely impacted by their daily protocol. Members typically suffer from a variety of mobility issues, some associated with age and others a potential aggravated condition from long term

[8] Master Sheng-yen. Establishing Global, Shared, Ethical Values through Education. Prevention of Terrorism: Enhancing World Peace through Education and Facilitating Global, Shared Ethical Values" Conference. UN Dag Hammarskjöld Library. January 2004.

[9] Tribe, Cassandra. Shouting in a Silent Room: Rethinking Meditation and Serious Mental Illness. Patriarch's Vision. Vol 1. Issue 3. ICBI Press. UK/Beijing. March 2014.

psychiatric medication – participants may range from fully ambulatory, athletic, require walkers, canes or mobility scooters.

The study proposed to use a statistical analysis of behavioural patterns in lieu of biological metrics. The principal behind this choice is based within the theory of paleontological speech analysis and its detection of intent, effect and existential value/context in persons with schizophrenia. The assumption that this would be appropriate for this community, which has a range of functionality and diagnoses, is based on studies that show how quickly independent and critical thinking is impaired by exposure to the public and private Western mental health treatments and how chronic medication can cause a confusion of cognitive and communicative abilities without compromising the intent and thought of logical communication.[10]

Through a careful review of studies that isolated the effects of movement and meditation on the overall mental, emotional and physical health of healthy communities, enough evidence was present to suggest that the problems inherent in introducing the same techniques of movement and meditation as adjunctive therapy for communities with mental illness came not from the unpredictable participant responses that create a risk with this population, but from the formation of the approach and presentation of programs by designers and facilitators who are working without guidance from the population as to what of the intended program was accessible and of use to them in the present. This suggested that the usual vertical design and implementation of mental health support programs was ineffective with communities with mental illness but that by using a mass line development and implantation approach, a lateral program could be successful implanted

[10] Van Den Tillaart, Kurtz and Cash. Powerlessness, marginalized identity, and silencing of health concerns: voiced realities of women living with a mental health diagnosis. International Journal of Mental Health Nursing. June 2009.

without a noticeable risk undertaken.

A core misunderstanding of meditation is that the positive reinforcement of the practice lay in the result of creating a more relaxed physical state. While that is a measurable effect in healthy populations, that this is an outcome of meditation is considered to be incidental and not guaranteed or sought by advanced practitioners as it is not considered a reliable positive reinforcement of the practice. The state that is sought to be created as positive reinforcement through the practice of meditation guarantees neither relaxation, decrease in stress or insight; instead the repeated effect is to enter into a condition best described as "safe harbour."

Safe harbour being defined as the state in which there is enough disassociation from immediate emotional states and control over physical action that the practitioner may then choose to explore the current distress, contemplate a topic, or choose to recreate stress in order to explore it without having it cause ill effect outside of the designated time period of practice. It was thought that participants with mental illness would benefit from learning techniques to create at will such a state of safe harbour so that even if they were unable to diminish stress, distress or anxiety that they would be positively reinforced by entering a state in which their choice of action and reaction to it was under their control.

This state of safe harbour was also projected to allow for those with functioning psychosis to be able to participate and share their experience of emotions, moods and daily life within a group setting so their language and experience would be understandable and accessible to others in the group to promote a sense of belonging to the community and ability to give and receive support within the community as well.

It was thought that by adapting the theory of mass line thought to the design of a moving meditation and seated meditation program that the program could become inclusive

of, behavioural operants identified within the community to dynamically change the design to increase its effectiveness while reducing any associated risk. Through using mass line analysis and implementation, the program could adhere to the guidelines of health and wellness defined by the community directors as necessary to promoting support and recovery while allowing the participants to experience the positive reinforcement of symptom management and self-regulation no matter what their mental illness or cognitive/physical functioning level. By using this approach, the goal was to identify patterns of behavioural momentum unique to psychiatric communities, to select specific areas for additional quantitative study in regards to the effect of the program on health and social capital standings, as well as to suggest a training approach for facilitators that would allow for similar programs to be introduced into other communities with the same fluid customization as the result. It was also the goal of the program to shift the understanding of meditation from one that was only successful in promoting relaxation to an experience in which success was determined by the participants' willingness to experience themselves in an effort to become better integrated in the world at any stage of their functionality.

Methods

Participants

Participants for the program were self chosen from a population of mental health consumers who are members at the Mental Health Care Advocates of Rhode Island/OASIS centre in Providence, RI (OASIS). At no time during the entire 12 months was it possible to anticipate the participation level for the day as participation was self determined and not required.

MHCA/OASIS (OASIS) has been in operation since 1985 providing a community centre for any persons who have

received treatment for any mental illness in Rhode Island. Up until 2012, OASIS functioned as a combination drop-in centre and meal site for those with serious mental illness, dual diagnosis and the homeless. The majority of the drop-in population was homeless with a high level of alcohol abuse and comorbid conditions. Due to a change in management in the middle of 2012, the focus of OASIS was redefined to place an emphasis on creating a recovery centre for those with any mental illness. Membership requirements are that the participant have received, or be receiving treatment in Rhode Island for a mental illness. Further requirements were instituted that to participate in the lunch meal program, members had to arrive early enough to sign in to be able to also participate in the wellness and recovery programs although they are not required to do attend any group and may just come to sign in, wait and eat. Applicants with issues of active substance abuse were also redirected to different programs in the area whose primary focus was substance abuse treatment. The guiding program OASIS uses as a source for their support structure are the Wellness Recovery Action Plan (WRAP)[11] and Intentional Peer Support (IPS).[12]

Anticipated participants represented a broad spectrum of mental illness, mobility and cognitive functioning level. The range of psychiatric illness within the membership can come from managed clinical depression to adult psychosis and schizophrenia among others. The level and length of medication for each participant is also widely varied with some exhibiting Tardive dyskinesia, tremors, balance issues, cognitive functioning and problems with staying awake while others are barely impacted by their daily protocol. Members typically suffer from a variety of mobility issues, some associated with age and others a potential aggravated condition from long term

[11] Mary Ellen Copeland. Wellness Recovery Action Plan. The Copeland Centre. Brattleboro, Vermont.
[12] Shery Mead. Intentional Peer Support. Bristol, Vermont.

psychiatric medication – participants may range from fully ambulatory, athletic, require walkers, canes or mobility scooters.

At the start of the program, the presenting population contained a higher percent of conditions associated with comorbid conditions of chronic homelessness and alcohol abuse, as well as those with serious mental illness that were wards of the state. The beginning statistics coincided with the change in management and an active drive to include more persons from the community at large with any mental illness. Rhode Island stands out in the US as having a higher than average percent per population of serious mental illness with 1 in 4 persons in Rhode Islandhaving received care for a serious mental illness versus 1 in 5 nationally.[13] Nine months into the study that census at OASIS more accurately portrayed a cross section of the state and national percentages of:

- Major Depression - 6.7% 18 and over, more prevalent in women, median onset 32
- Schizophrenia - 1.1% 18 and over, equally prevalent in both genders, median onset teens to 25 for men and late twenties to 30s for women
- Bipolar Disorder - 2.6% 18 and over, no gender data available, median onset 25
- Obsessive Compulsive Disorder (OCD) - 1.0% 18 and over, no gender data available, median onset 19
- Panic Disorder - 2.7% 18 and over, equally prevalent in both genders, median onset 24
- Post-traumatic Stress Disorder (PTSD) - 3.5% 18 and over, equally prevalent in both genders, median onset 23 * not including veterans
- Borderline Personality Disorder - 1.6% 18 and over, no

[13] National Institute of Mental Health. Health and Education: Statistics - Serious Mental Illness. 2013. Retrieved February 4, 2014 from http://www.nimh.nih.gov/Statistics/index.shtml

other data available.

The end of year census for OASIS membership most closely reflected the NIMH statistics for adults receiving service in Rhode Island by race and age with the median age being between the late 30s to late 60s. The OASIS population did not match the gender delineation for the state of 49% male and 51% female with membership being 60.5% male and 34.9% female. This also was not reflective of the national average of 4.9% females having serious mental illness compared to 3.2% male.[14] The potential discrepancy could be due to the lack of adequate transportation and public transportation issues to the location as well as a prior history under previous management of the centre not being safe for females.

OASIS has an average daily census of 21 members not including associate members and members attending as volunteer or paid staff. They are open 5 days a week from 10am until 4pm. The sessions were scheduled Monday through Friday from 11:30 am to 11:55 and from on Mondays and Thursdays there were additional sessions from 2pm to 2:25pm as well.

Materials

The materials used in the project fell under two different categories – session use and home use. They were further separated into phase I (Table 1) and phase II (Table 2) introductions.

[14] Mental Health Care Advocates of Rhode Island/Oasis. 2013 Population Census Report. February 2014.

Table 1 – Phase I materials

Phase I	Session Use	Home Use
January 2013	Traditional Meditation Bell, Pali Chant music	
February 2013	Traditional Meditation Bell, Pali Chant Music	
March 2013	Traditional Meditation Bell, Pali Chant music	Meditation CD
April 2013	Traditional Meditation Bell, Pali Chant music, nature sounds	Meditation CD
May 2013	Traditional Meditation Bell, Pali Chant music, nature sounds	Meditation CD
June 2013	Traditional Meditation Bell, Pali Chant music, nature sounds	Meditation CD

Table 2 – Phase II materials

Phase II	Session Use	Home Use
July 2013	Traditional Meditation Bell, Pali Chant music, nature sounds, focus objects, Zen/OASIS app	Meditation CD, Zen/OASIS app
August 2013	Traditional Meditation Bell, Pali Chant music, nature sounds, focus objects, Zen/OASIS app, Long Jin	Meditation CD, Zen/OASIS app
September 2013	Traditional Meditation Bell, Pali Chant music, nature sounds, focus objects, Zen/OASIS app, Long Jin	Meditation CD, Zen/OASIS app
October 2013	Traditional Meditation Bell, Pali Chant music, nature sounds, focus objects, Zen/OASIS app, tape markers, rope balls	Meditation CD, Zen/OASIS app
November 2013	Traditional Meditation Bell, Pali Chant music, music (varied culture and type), nature sounds, focus objects, Zen/OASIS app, Long Jin, tape markers, rope balls	Meditation and Movement DVD, Zen/OASIS app, rope balls
December 2013	Traditional Meditation Bell, Pali Chant music, music (varied culture and type), nature sounds, focus objects, Zen/OASIS app, Long Jin, tape markers, rope balls, rope pulls	Meditation and Movement DVD, Zen/OASIS app, rope balls, rope pulls

Material Definitions:

- *Traditional Meditation Bell* – Brass toned bell with striker, Zynergy brand mounted chime, Dharma timer bell app
- *Pali Chant Music* – Pali chant of the Heart sutra with music
- *Varied Music* – Varied music styles with chant or slow rhythmic patterns, Chinese, Western, Modern & traditional styles
- *Nature Sounds* – Free Nature Sound Meditation Android Apps, custom mixed ocean recordings with buoys and bird highlights
- *Focus objects* – Variety of small coloured glass stones, larger river stones, large sandstone rock, crystals of varying sizes
- *Zen/Oasis app* – Mobile app developed using apps bar with multi functionality and password protected session report form (Note A)
- *Long Jin* – 8 minute form developed for project of Isometric, Isotonic and traditional Qi Gong movement
- *Tape Markers* – Pale green masking tape set on floor to provide reference point for placement of feet during movement
- *Target Mitts* – Punching target mitts
- *Rope balls* – Rope ball dog toys used as focus objects and grip exercises balls
- *Rope pulls* – Tug-of-War dog toys used for isometric and isotonic exercise
- *Protective gloves* – Polyester/cotton work gloves with fingertips removed for use with target mitts

Design

Facilitators follow the outline defined in the Procedure section

with minimum deviation. Pre-study training for the facilitators (one regular and one volunteer) focused on non-verbal pain assessment techniques, conversational terrorism avoidance[15] basic Shaolin Qi Gong theory, movements and breathing patterns, Chen Tai Chi 18 move short form in full and adaptive stances, basic isometric and isotonic exercises, basic sports stretching and physical rehabilitation exercises for joints, exercise and balance. Meditation practices drew from routines and fundamental meditation practices covering Zazen, guided meditation, Ericksonian Hypnosis methods and associative prompt techniques adapted for the specifics of this study. (Note B)

Session documentation tracked participant number per session part, time devoted to each part of the session, techniques used, mass line input and additional topics discussed during session time and outside of the direct session time. Documentation was tracked via a spreadsheet using a proprietary Android app with a password protected session access mode to communicate with a password protected Google drive spreadsheet. Trend analysis and mass line input notes were reviewed weekly to allow for revision of the program and additional training as needed for the facilitator. Every 4 weeks an average census was computed of the individual session parts and session whole along with an averaged topic trend analysis. (Note C) Only trends with a monthly incidence higher than 4 were counted in the ongoing adaptation of the program parts.

Procedure

1. Facilitator enters the site 15 to 20 minutes before the start of the session. This time is used to talk with community members whether they are participants or

[15] VanDruff and VanDruff. Conversational Terrorism: The Art of Conversation. 1995 Retrieved February 18, 2014 from http://vandruff.com/art_converse.html.

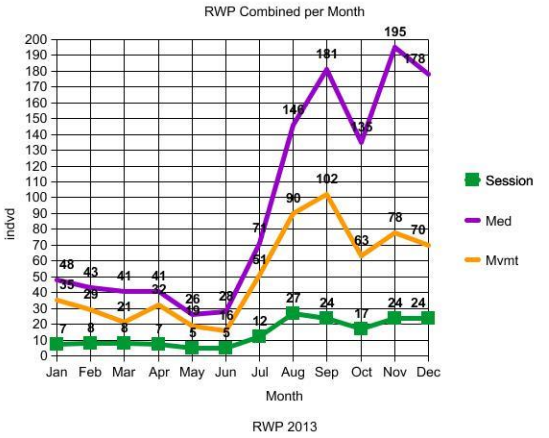
not. The facilitator is not to promote the program but to engage in purely social interactions. Time is also used to get materials ready and to have any discussion with staff that is necessary.

2. At the start of the session time, the facilitator walks to the area but does not announce the session. An announcement may be made by one of the community staff members or volunteers. The first part of the session consists of moving meditation practices.
3. The moving meditation draws from traditional Shaolin Qi Gong, Chen Tai Chi and Northern Shaolin Kung Fu forms as well as demonstrating manual lymph drainage techniques, giving breathing exercises, isometric and isotonic routines. The moving part of the session is to last no more than 15 minutes and the time frame to be adjusted according to participant focus and physical stress level expressed or noticed. If there are those present with mobility issues the facilitator can demonstrate three different options with the positions with each move, or conduct the whole session from a chair. When appropriate, resistive and positioning touch should be used. (Note D)
4. Prepare for meditation by asking one of the moving meditation participants to set out an appropriate number of chairs in a circle. A staff member or volunteer should announce the meditation session while the facilitator leaves the area and walks through to prompt people known to participate that the session is occurring. Facilitator is never to ask if someone would like to participate in meditation more than twice in one month, they are always to respond to any comment on why someone can't join that day with an invitation to join whenever it does feel right for them.
5. Short explanation of whatever meditation technique will be used and explanation of the different ways in which

people may express relaxation. (Note E) The facilitator then announces the session will begin and reminds the group that the facilitator will "come get them when it is time to come back" and to reaffirm that the only rule is that you cannot stay in a place that you do not want to be while meditating, facilitator offers phrases to help break out of cyclical thoughts and begins the session by counting down, doing an induction or ringing a bell three times.

6. During the explanation, pass out the options for focus objects and explain that they are optional and how some people have used them. (Note F)
7. Meditation sessions are never to last more than 8 minutes with 3 minutes being a minimum. Facilitator should gauge the participants focus and tension visually to adjust the meditation time as is appropriate. To end the meditation, ring bell three times.
8. Briefly ask each participant "how was that?" and if appropriate, also ask if there is anything they liked or didn't like about it with a stated reminder that the session can always be altered so they suit people better. Discussion should last no longer than 4 minutes. The facilitator so bring the entire session to a close with 5 minutes free before lunch or the next scheduled group.
9. Facilitator cleans up. The facilitator is not to ask for assistance in cleaning up but may accept it if offered. As soon as possible after the session, the session data should be submitted.

Results



- There were 156 sessions recorded over 12 months with 1362 total minutes applied to active participation in the defined procedure with 2538 minutes used for the set-up, clean-up and reporting for the program. 5460 total minutes were allowed with active entry time included over the entire 12 months.
- Of these sessions, 79 occurred during the morning and 77 were afternoon sessions. The months from January 2013 until August 2013 only had sessions in the afternoon.
- The average individual session participation for the morning movement section was 4.00 participants
- The average individual session participation for the morning meditation section was 7.75 participants.
- The average individual session participation for the afternoon movement section was 3.81 participants.
- The average afternoon individual session participation for the afternoon meditation section was 5.5 participants.
- The average movement section was 10.13 minutes in length.

- The average meditation section was 7.81 minutes in length.

The combined daily average participation for the Responsive Wellness Program was 12 individuals per day participating in one or more sections and sessions with an average overall time per session of 18 minutes excluding procedure allowed entry time.

The average daily lunch census for OASIS is 21. The average estimated afternoon census is 12. Daily attendance fluctuates according to the time of the month which is thought to directly correlate to the receipt of state and federal benefits as well as be tied to the once monthly psychiatric review requirements that many members must participate in to be considered compliant by other agencies.

The participation trends fell within expected regions with several noted exceptions.

- The drop in sessions and participation in May and June correlates to the lead facilitator being incapacitated due to injury. The program was briefly suspended for two weeks and then resumed.
- Participation began to rise in late June and July. This is mostly attributed to the better weather and a responsive change to the meditation formula from a strict guidedprogram or silent meditation to one that used more open instruction, flexible imagery, focus objects and tasks.
- The participation rose dramatically when the program was expanded from its original schedule of two afternoon sessions a week to include an additional 5 morning sessions beginning in August 2013. A volunteer facilitator was trained and brought in at the end of August to take over the morning sessions.

- The dramatic decline in participation between September and October correlates to the evaluation of the volunteer coordinator as having an inappropriate leadership style that was overly aggressive and rigid. Removal of the volunteer facilitator occurred mid-way through October and there was a corresponding spike in participation that then receded back to what are expected levels for the age of this program and the participant exposure to it.

Over the 12 month time, the following topics were identified as of key areas that participants were wanting more education, practice, resources and discussion on (presented in descending order of importance):

1. meditation techniques
2. relaxation techniques
3. social interaction
4. fitness tips for mobility issues
5. anxiety relief
6. breathing techniques
7. alternative therapies
8. methods to improve focus and concentration
9. learning and memory improvement
10. mindfulness
11. sleep problems
12. weather
13. energy (as related to concept of Qi and healing)
14. movement
15. pain management
16. relationships (building and sustaining)
17. therapy (complementary and alternative physical and emotional styles)
18. treatment (alternative pain and anxiety treatments)
19. increase self control

20. accessing and using local gyms (developing comfort level)

There was a noted developmental path of trending topics that followed an expected route from social interactions being the primary focus in the beginning months to the later months, as the program became an established presence, that the trending topics began to focus more on different techniques for relaxation, meditation and other means of coping. There was a shift in mid-October from the techniques being presented in the after discussion being a result of the facilitator being asked for information to the group sharing information about how they had used or applied techniques they had learned in the sessions, or discovered elsewhere. The group began to cross educate themselves with the facilitator's role being one of making sure that the conversation did not get monopolized by one view or opinion and that it did not run the session over time by the end of November.

Discussion

In order to properly discuss the suggested findings of the study, it is necessary to split the discussion into three areas – movement, meditation and mass line. Each of the areas inter-relate and used self-contained materials that were distributed at four different points during the process – the Android app, a CD of meditation recordings, the introduction of focus objects and a DVD of meditation and movement videos. Central to the program, which was named the "Responsive Wellness Program (RWP)" was the mutual agreement between the author and guiding agencies of MCHA/OASIS that what was possible as the benefit of introducing movement and meditation practices could far exceed expectations if it was done with a lateral community developmental approach, rather than applying the

standard clinical vertical top down implementation of complementary programs.

It should also be noted that the majority of the background research for this study originated in European and Asian studies that have not been generally publicized or adopted bythe American mental health community as it runs contrary to the central premise of Maslow's Theory of the Hierarchy of Needs which is used as the backbone in most complementary and supportive therapy programs in the American Social Welfare community. Instead, the theory of the mass line was adopted in which the assumption is that while there exists a defined structure of needs, the primary need is for one of self-esteem and belonging through purposeful and meaningful contribution to community.

The implementation of ways to meet individual needs in a communal setting must be determined by the community and not the agency. The agency best serves to maintain and make resources available to achieve the common goal of mental health and wellness, but the community is always assessed using the mass line to know which of the resources is currently in need.

This lateral form of implementation disposes of the vertical hierarchy of bureaucratic mental health treatments that place the client at the bottom of the priorities of achieving health. In measuring mental health and wellness, the goal was also to abandon efforts to normalize the experience of living with mental illness and to instead seek to affirm the supporting community membership while using social proof to show that the marginalized community shared much in common with the larger community while maintaining a distinct identity rooted in the experience of living with a Serious Mental Illness or Any Mental Illness.

Movement

The vehicle chosen for movement was the traditional Chinese forms found within the Northern Shaolin Qi Gong and Gong Fu styles. These original styles developed at the same time as yoga practices in India as their origination coincided with the split of the Hindu and Buddhist belief system. Each belief system recognized that the integral use, discipline and mastery of the body were essential to maintaining and creating physical, emotional and mental health. Movement practice is considered one of the earliest forms of meditation and the most accessible, particularly when taught with its emphasis on breath control. The movement section was placed before the seated meditation to encourage more people who would not normally be willing to try meditation to explore it in a more accessible environment of movement. It should be noted thatpart of the history of Chan Buddhism allows for the adoption of current and modern forms and practices in order to allow for easier development of a meditation practice.

An additional reason for choosing tradition Chinese forms such as Qi Gong, Chen Tai Chi and Gong Fu was that all of them have an association with power, independence and survival in Western Culture. The mythos of the Chinese martial arts is shared across the American culture in particular and by presenting movement and exercise in this fashion, a marginalized community that was getting an adaptive form of the techniques was able to connect to a broader cultural anchor within the community at large increasing their social capital. Rather than doing "hospital exercises," participants were learning Tai Chi and Qi Gong. They were also frequently reminded that everything they were learning was also being taught by the same facilitator to classes with participants from outside their community.

It is unique to a population with Serious Mental Illness that they typically have a "perfect storm" of issues that will

complicate any type of training or practice with movement or exercise.

The first issue comes from long term medication. Many psychiatric medications have a serious impact on balance, memory and visual perception, as well as causing muscle fatigue, cramping and/or joint inflammation. Add to this the additional effect of psychiatric medication, along with many other types of medications common to this population such as those for diabetes, high blood pressure and high cholesterol and the effect on the body's ability to regulate body temperature becomes radically altered. One of the choices made in creating the movement part of the program was to not separate participants into groups by abilities, but to focus instead on doing a mutli-level accessibility presentation of every exercise to foster a group environment where accommodating different skills and ability levels was the norm and viewed as part of the skills of the group set. The traditional learning process of both Qi Gong and Kung Fu is designed to be adaptable to different physical skills in order to promote healing and health as well.

The second issue stems from the devaluation of the individual in regards to respect for their communication and contribution of constructive criticism from the participants towards the program and facilitator. In general, those who have been exposed to the American mental health care system are taught that they do not have input that is of value because they are ill.[16] They also quickly adopt the self-disparaging view that as someone with a mental illness, their contributions and potential contributions to the community at large are null and void. They wholly personify the designation of "consumer" to the point that they do not feel competent in communicating their physical or emotional reactions to situations when asked. When asked to self-report, the population tends to default to a

[16] Mary Ellen Copeland. Wellness Recovery Action Plan. The Copeland Centre. Brattleboro, Vermont.

form of speech that echoes clinical terms and serves to further their disassociation from their present experience as something that is valid for the uniqueness of its experience.

The adoption of institutionalized vocabulary serves to further devalue their life experience and hinder the ability to use complimentary practices. This made the inclusion of a paleontological approach imperative in the mass line assessment design as it was recognized that without the facilitator and assessor learning the ontology of the participants, no accurate results could be presented, or effective program implemented.

Part of the facilitator's role was to continuously reflect and affirm the life experience and validity of the group membership being open to all members and that the group session could fluidly adapt to be inclusive as all. Uniformly, this was successful with some prominent exceptions. For example, during the brief time that one volunteer facilitator was in place, the emphasis shifted to there being a defined, single goal for all and single set of movements to achieve it. This resulted in some members using clinical and institutional terms towards other members of the community to tell them that they "couldn't do the movement part and had to wait until the meditation because they would hold everyone back." This exact phrasing was documented from four different participants. The volunteer facilitator was removed, and the issue was addressed by reaffirming the adaptability of the group and through contradicting the bias statement.

This brought up an important issue in handling and testing the extent of facilitator training and skill. It was found that the facilitators who had trained a minimum of 2 to 7 years in a Buddhist identified Western school or program had the least ability to identify distress or to respond to stress within a group environment. The striking consistency of their rigidity of thinking and behaviour was the basis for eliminating potential facilitators who listed Buddhist training on their application

from consideration. Exceptions were made for those willing to undergo an intensive training process at Dragon Mountain that adopted hospice oriented methods of teaching non-verbal pain assessment, compassionate communication and detachment with awareness that then passed a hospice based evaluation of compassionate care ability. It should benoted that the same was found to be a defining consistency among applicants listing a background in New Age meditation as well, and the other common factor was the lack of awareness of the scope of meditative practices within each respective tradition.

Homo-lateral and Hetero-lateral Movement

During the initial months of the movement practice, several of the most regular participants had difficulties with balance, physical memory, and memory of sequences and lacked the ability to tell their left from their right.[17] A break through session came when the facilitator opted not to lead the class but instead had two volunteers come forward. One person, who was more physically able cognitively aware, was the "moved" and the other person, a man with very poor sequential memory, balance and the inability to tell his left from his right played the role of the "mover." The Mover had to verbally instruct the Moved how to do a sequence that the facilitator demonstrated silently to the Mover. What came of this was the discovery that the man's balance and muscle difficulties had been so profound for so long that he ceased to think in terms of right foot and left foot and only identified parts of the body by clothing and shoes. This led to the facilitator dropping the use of foot and hand from the vocabulary used with the group and adopting shoe and glove for most of the movements.

[17] Boker, S.M., Leibenluft, E., Deboeck, P.R., Virk, G. Postolache, T.T. Mood Oscillations and Coupling Between Mood and Weather in Patients with Rapid Cycling Bipolar Disorder. Int J Child Health Hum Dev. 2008.

The additional introduction of the Chinese concept of Dragon, Tiger and Gate to represent the forward and receding sides of the body in a pose, rather than right and left sides, further reduced confusion on the direction of movement for all members of the group. This base realization that the length of time living with impaired cognitive function acted to disassociate connection to the body as something that was connected to the person led to the introduction of resistive touch in group. Resistive touch is a teaching technique used with Qi Gong and tai chi to teach the participant the proper amount of muscle tension to hold while moving. For example, if a hand is moving downward, the facilitator will place their hand under the participants, so the participant is pushing down against a resisting force. This allows them to experientially learn muscle control for the movement.

Part of the Qi Gong movements that were also introduced are designed to alleviate loneliness, consisting of a series of brushing movements that imitate comforting touch done in a pattern over the body. The combination of these movements, with resistive touch, brought to the group human contact – something that is denied people with mental illness who are inpatient, outpatient or who are in support communities. The importance of touch has been proven essential to maintaining mental health.[18] The use of the Qi Gong touch pattern and partnered resistive touch (the facilitator teaching participants to do it in turns) allowed touch to re-enter participants' experience of community without the touch being of a sexualized nature or overly intimate.[19]

The other adaptation to the original formula of the movement section was to become more cognizant of the effect of

[18] Morrisey and Callaghan. Communication Skills for Mental Health Nurses: An Introduction. McGraw Hill Education. Berkshire, England. September 2011

[19] Hertenstein MJ1, Holmes R, McCullough M, Keltner D. The communication of emotion via touch. Emotion. Aug 2009

barometric pressure on participants[2014], with highs and lows leading to increased joint stiffness. A more flexible routine of movements and exercise were used that all drew from the same core form sets, but the actual teaching of sequential forms was abandoned early on in favour of working on isolated sequences. This was the result of a mass line analysis that emphasized the need for feeling a mastery of the idea of a movement in a single session rather than trying to create a multi-session attendance requirement that many would not be able to make, and thus felt as if they could not attend at all.

Introducing Meditation Practices

The meditation portion of the session was the one that was greeted with the most anticipation by the community. Often denied inclusion in meditative programs in social welfare agencies because of concerns of "stability" or only offered guided meditations and hypnosis - many members had pursued a wide variety of meditative practices on their own. No less than 2 members reported being specifically told by their mental health counsellors at other agencies that meditation wouldn't work for them because they had a mental illness. It was one of the few areas in which the most members reported a willingness to leave the comfort zone of a community of similar life experiences and to walk into a community of unknown experiences and commit to participate. Several members had also made it their habit to listen to meditation lectures and tapes found on the Internet. The identified problem with introducing a meditation session was not having to introduce the concept, but to make sure the appropriate expectations were in place for the effects of mediation and to find a way to adjust to the varied attention and focus abilities, as well as

[20] VanDruff and VanDruff. Conversational Terrorism: The Art of Conversation. 1995 Retrieved February 18, 2014 from http://vandruff.com/art_converse.html.

motor control issues and anxiety that were present in the community as a whole so the meditation session would not be exclusive.

The Safe Harbour and Silent Sitting

Meditation sessions were designed to last between 5 and 8 minutes to accommodate physical and cognitive limitations. Facilitators were told to present multiple aspects of meeting guidance for the session (eyes closed, eyes open, and feet flat or crossed ankles) and trained in nonverbal pain assessment to gauge when a session should end to preserve the stability of the group. The form of silent sitting that is popularized in the West was de-emphasized and returned to its traditional role of an advanced form of meditation. Emphasis was placed on training the awareness of, and skill in, controlling thoughts and physical reactions.

A pattern of different types of meditation that used leading sounds, words and interruptions in order to allow participants "permission" to change thoughts or to leave emotional states proved most effective. The use of focus objects also served to transform the amount of participation and willingness to participate in the group. The focus objects ranged from small stones and smooth glass pieces that could be mindfully observed to rope balls and rope pieces that could be tugged and squeezed as an outlet while remaining still. By the end of six months, silent sitting was introduced and remains as an option performed once or twice a month to great success.

Much of this was due to training in what was called "safe harbour." As mentioned before, it removes the unrealistic expectation that meditation is to make one feel good or relaxed and instead reintroduces the traditional concept that it is a time for contemplation that could bring any feeling or no feeling but never resulted in one having to remain in an emotional state when done. The meditative period, for many, became a

time where they could choose to escape, to relax, to focus on problems or to reinforce positive memory recall.

The Mass Line and Meditation

Mass line analysis was used at the end of each meditation session by the facilitator encouraging each participant to share what they would have changed about the session, or what worked best for them. This is a radically different approach from the standard encouragement to share the individual experience. This approach resulted in more members of the group connecting and voting on what would make a better group experience, as well as making it alright for one individual not to have a good session and yet still come back for more. The mass line approach created a behavioural operand that meditation was necessary to living a life in which life was not overwhelming in either good or bad ways. It reduced extremes of emotional reactions to the point that 95% of the participants self-reported that they were using the techniques at home as a way to end or begin their days because even if they did not enjoy or experience relaxation during the meditation, they felt that it made it easier to get through the day.

As a result of the group, input facilitators were encouraged to expand beyond their known training and routines and to find new ways to bring in different lessons and exercises in meditation. Half of the facilitators have chosen to begin intensive and daily study in sutras and to practice meditation as a part of their daily routine; whereas 80% of the facilitators trained and placed at the beginning – despite meditation backgrounds for many, reported meditating less than one time per week and having limited to no exposure to canonical texts.

Conclusion

While much was learned and more was discovered to investigate, the reality is that the program is continuing to exist in MHCARI/OASIS staffed by Dragon Mountain trained facilitators. To this end, continued documentation and development of a program of training for facilitators in the compassionate leadership and the wide variety of meditation techniques within the Chan School continues. The group at MHCARI/OASIS has stated a long term goal of trying to create a program that can be exported to other wellness and recovery centres to support those with Serious Mental Illness. It should be noted that going into the second year of the program, the diagnostic ratio within the MHCARI/OASIS population has shifted in response to the cuts in U.S. government funding for Serious Mental Illness treatment and support. There is a stronger presence of those suffering from Post-Traumatic Stress as well as tactile hallucinations and psychosis. It is the findings of this first year's study that has allowed the group to fluidly change the meditation techniques used to allow for safe inclusion of those with potential behavioural triggers without one person in the group feeling as if they have been displaced. Even in instances where the sessions have been disrupted due to crisis, the group and the facilitator were mutually supportive in resolving the crisis and reclaiming a space of wellness.

Going forward for Dragon Mountain, the results of the study have served as a call to return to traditional disciplines and teaching methods that accommodate modern needs, but donot let go of the depth and value of tradition. In regards to developing an effective training program for facilitators westernized interpretations of Buddhism and meditative practices are being de-emphasized in favour of the core developmental practices of the Chinese Chan tradition practiced prior to the 1800s and the introduction of neuro-biological and physiological training for non-verbal pain

assessment and behaviour operands is being taught alongside the process of mass line assessment as an on-going tool for improving service. It is the hope that through the structured development of a facilitator training program that the methods of application will become portable to any center for supporting those with mental illness.

NOTES

A. Using the AppsBar free Android App developer online, the free Zen-Oasis App was created and distributed via the Android App store. The purpose to the app was to provide supporting material for use outside of the center for symptom management and stress relief. The app has 24 components:

1. About – general overview of program
2. Daily – suggestions for daily practice
3. Diet - educational information about improving diet
4. Wellness educational information about improving self-management
5. Anxiety – educational information about improving self-management
6. Meditation – explanation and suggestions for varying mediation techniques
7. Timers – preset mediation timer recordings
8. Qi Gong Taiji – summary of Qi Gong and Tai ji
9. Long Jin – page demonstrating physical movement set being developed for limited mobility
10. Videos – links to videos demonstrating Qi Gong and other techniques
11. The Game of GO – overview of the game of GO and its connection to mental health
12. Blog – link to the Dragon Mountain blog
13. Contact- email and form contact information

14. Jigsaw – a sliding tile puzzle
15. Jigsaw - a sliding tile puzzle
16. Jigsaw - a sliding tile puzzle
17. Jigsaw - a sliding tile puzzle
18. Jigsaw - a sliding tile puzzle
19. Jigsaw - a sliding tile puzzle
20. Mandala – a freehand drawing program in which you cannot save the image.
21. ELIZA -ELIZA is a computer program and an early example of primitive natural language processing. ELIZA operated by processing users' responses to scripts, the most famous of which was DOCTOR, a simulation of a Rogerian psychotherapist
22. Test – dedicated test page
23. The Good World – this is a placeholder for a project in development
24. Session 1 – this is the tracking aspect of the app. It is password locked and only accessible to the facilitator.

B. Meditation practice drew from the routines and fundamental practices and exercises associated with Zen (silent sitting, counting breaths) and also included compassion practices and mantras. Also, guided meditations in the form of using Ericksonian hypnosis inductions (the elevator, the butterfly) were introduced. The use of an intermittent bell through the meditation, even if it was a silent meditation, was adopted as a means to allow participants to practice gaining control of their thoughts and return to focusing on being a part of the group. One other technique that proved successful was to listen to a mix of natural sounds and towards the end, the facilitator recites a list of word (sunrise, beach, waves, forest, peace and so on) that the participants may choose to follow or not.

C. The session form was designed and implemented using Google Docs. After each session the facilitator recorded:

- The time of the session (AM or PM)
- The number of participants for Qi Gong
- The length of the Qi Gong session
- Objective comments about what forms were used and participant response.
- The number of participants for the meditation session.
- The length of the meditation session
- Objective comments about what forms were used and participant response.

Additional sections of the tracking form were used to provide information on: Trending topics discussed from the moment facilitator entered the building, during the sessions and after. Topics were entered as single word items in a comma delineated form for later analysis.

- Subjective comments from the facilitator.
- Operation notes.
- An estimate of the AM or PM.

Data was compiled on a monthly basis with trending topics and participant session responses used to shape plans for the new month. A copy of the attendance and top trending topics was given to Oasis management at the end of each month.

D. In an environment in which all touch is discouraged/prohibited out of concerns for personal safety (except for the pop culture "fist bump), the decision to include resistive touch as a means of instruction was reached as a means for furthering bonding and feelings of connection within the group. Resistive touch is done by the facilitator giving a verbal description of the nature of the touch to be done (i.e. the participant pushing their hand against the facilitator's hand who is resisting the touch) always makingsure to allow the

participant to initiate actual contact with the facilitator only passively responding.

Once a participant was used to a pattern of resistive touch in which they were the initiators, knew what to expect and has received the operant feedback of gaining a positive skill – if necessary, the instructor could then move to initiating positioning touch - a guiding touch on the shoulders, elbows or wrist only (and tapping of knee cap) to correct posture and position. The facilitator always announced that they were going to touch the participant and what to expect as well as what to learn from the touch. At no time was intimate touch - such as hugging, hand holding or comforting introduced. Instances in which this occurred where kept outside of the center and had to be initiated by the participant and appropriate.

It was the facilitator's own reading of the participant to deem whether or not a handshake would be appropriate when first meeting. By reintroducing safe and purposeful touch to the group, the group was then able to move into a space where doing paired exercises was possible and evidenced more physical safety with the group then without it. It should be noted that one of the hallmarks of a medication decline with several of the participants was an insistence on hugging or hand shaking. Levels of appropriate communicative touch were based upon a minimum of 3 months observational and interactive knowledge of the participant.

E. In the opening explanation of how to sit for meditation the facilitator emphasizes the following:

- There is no wrong way to meditate.
- Some people sit perfectly still, and some people move.
- It is recommended that you sit with your feet flat on the floor, or with your ankles crossed to allow for a better feeling of being grounded and for better circulation.

- Some people meditate with their eyes closed and some with their eyes open. If you are want to do a mix that is alright.
- While you are sitting, relax your breathing and just breathe evenly in and out.
- Some people finding counting their breaths relaxing. Other people don't count.
- There is no wrong way to do this, but there are two rules:
    - You aren't allowed to stay in any place or with any thought that doesn't feel good for you. If you go there, tell the thought to go away, you are busy, or - use the bell I will ring throughout the meditation as your opportunity to change what you are thinking. The bell is your permission to leave and go somewhere better.
    - If you feel uncomfortable for any reason, just get up quietly and leave. Some days are better for meditation than others, just come back and try it again sometime.

F. Focus objects consisted of a variety of polished rocks, rope balls, rope twists and bamboo rings. Participants were offered the choice of holding one or more focus objects while meditating with the following examples of how people often use focus object.

- You can sit and hold the object lightly and mindfully focus on its weight and texture.
- You can choose two different types of objects and contrast the weight and feel between them
- You can see if you can change the perception of the weight of each object.
- If you are holding the stones you can focus on noticing how they pick up your body heat.

- You can squeeze the rope balls, pull on the rope pull or twist and grab the ring. Moving during meditation in a pattern can sometimes help you relax.
- Passing the object back and forth between your hands is also an option.