

Music therapy in a recovery-oriented ward: A qualitative study of users' and staff's experiences with music therapy in mental health care

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Abstract

Service provision within mental health care is shifting towards services that maximize personal recovery. In a Norwegian context, national treatment guidelines have recently recommended that music therapy be part of such service provision. This study explores the implementation of music therapy in a recovery-oriented unit of a community mental health institution. Users and staff were invited to participate in focus groups with the intention of gaining knowledge about how music therapy fits in with, and contributes to, the overall service provision and to the support of recovery. The findings document aspects of how

music therapy can support personal recovery, how music therapy adds to the service provision as a distinctive therapeutic alternative, and how music therapy interacts with other treatment options on the unit. In sum, participants' experiences with music therapy within this specific facility highlight music therapy's role as a potential resource that contributes to recovery-oriented service provision.

Introduction

Mental health care services have moved towards a recovery orientation as a main guideline for service provision. Recovery perspectives have developed into a highly-promoted guiding principle for mental health care services in several countries, including the UK, Norway, Ireland, the US and Australia (Le Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011; Slade & Wallace, 2017). In a Norwegian context, this political shift towards recovery-oriented service provision can be exemplified by the National Guidelines for the Treatment of Psychosis, published in 2013 by the Norwegian Health Directorate. In these guidelines, the recovery perspective is presented as one of the underlying values informing the treatment of psychosis (p. 29). The same guidelines also promote music therapy as a warranted type of treatment, given the highest level of recommendation and the highest grade of scientific evidence, and emphasize that services should be provided by qualified music therapists¹.

The recommendation of music therapy is based on a growing amount of research in the field, both nationally and internationally, constituting a relatively solid evidence base for the practice of music therapy in mental health care. The research comprises effectiveness studies, RCTs and meta-syntheses of music therapy for serious mental health problems (Erkkilä et al., 2011; Gold et al, 2013; Gold, Solli Krüger, & Lie, 2009; Mössler, Chen, Heldal & Gold, 2011), as well as studies of users' perspectives (Ansdell & Meehan, 2010; Rolvsjord, 2015; Silverman, 2006; Solli, Rolvsjord & Borg, 2013;). Despite strong recommendation in the national guidelines, music therapy has not yet been widely implemented in Norwegian mental health care institutions. There are, however, recent initiatives to more systematically implement music therapy within innovative medication-free treatment options and as part of the new "treatment packages" orientation to mental health service provision in Norway.

¹ Music therapy education is offered at the master's level in Norway. There is, however, no formal authorization for music therapists.

This article will focus on the implementation of music therapy in a recovery-oriented outpatient and day-care unit in a Norwegian community mental health care institution. The study focuses on one case of the implementation of music therapy, with the purpose of exploring how music therapy interacts with other elements of the service provision . Focusing on this particular recovery-oriented unit, this article will address the following research questions: How do service users and staff experience music therapy as part of the recovery-oriented service provision? Implicit in this, the article will also explore: How does music therapy align with, and contribute to, the recovery orientation?

The Recovery Orientation in Mental Health Care

Perspectives on recovery in mental health have gained increasing influence since the new millennium. The early development of recovery perspectives in the discourse of mental health is often traced back to user accounts of their experiences of mental health and mental health care, which posed a strong critique of the dominant views (Anthony, 1993). With the notion of *personal recovery*, the concept of recovery does not imply or necessitate a *clinical recovery*, which in coherence with a medical use of the concept would imply recovering back to a state free from illness (Anthony, 1993; Davidson & Roe, 2007; Slade & Wallace, 2017). Instead the notion of personal recovery implies an individual's process of living a meaningful life with illness (Davidson, 2003). Thus, recovery can be understood as a personal process towards better life and promotion of positive health (Keyes & Lopez, 2002; Keyes & Martin, 2017).

The concept of recovery has increasingly been used to inform service provision (Anthony, 1993; Le Boutillier et al., 2011; Slade, 2009; Slade et al., 2014; Slade, Oades, & Jarden, 2017; Davidson, Tondora, O'Connell, Kirk, Rockholz, & Evans, 2007; Tondora, Miller, Slade, & Davidson, 2014). This implies a transition of ideas of personal recovery, as a

process owned and executed by each person, towards something that health care personnel provide or facilitate. This might be conceived of as a paradox (Davidson, 2003). Although this paradox might never be completely resolved, supporting each person's individual path in recovery may reduce such tensions. A review of the findings of studies of personal recovery (Bird, Leamy, Tew, Le Boutillier, Williams, & Slade, 2014; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) identified and validated characteristics of recovery processes, which are summed up with the acronym CHIME (**C**onnectedness, **H**ope and optimism, **I**ntity, **M**eaning in life, and **E**mpowerment). By building upon what people in recovery have identified as significant for their process, the CHIME framework proposes that service providers maximize the support of personal recovery. There are variations in the strategies and underpinning values for recovery-oriented services (Pilgrim & McCranie, 2013), but they share an emphasis on equal partnership and collaborations, the development of strengths and resources, and the promotion of hope and high degrees of self-determination and choice (e.g. Farkas, Gagne, Anthony, & Chamberlin, 2005). There is an emphasis on users' involvement in their own process, as they use the various parts of the service provision in interactions with other everyday-life contexts. This broadens the scope of therapeutic services to interact with the broader community, and to support users in social engagement and participation in interpersonal and community contexts (Tew, Ramon, Slade, Bird, Melton & Le Boutillier, 2011).

Seeing recovery as a personal process, something that people with mental health problems *do* themselves in living with their illness, a recovery-orientated service provision cannot be identified with descriptions of a set of interventions, but "needs rather to be the overarching aim of all services and supports" (Davidson, Tondora, O'Connell, Kirk, Rockholzt, & Evans, 2007, p. 31). Several descriptions of systemic and organizational transformations needed to move the services towards recovery orientation have been outlined (Anthony, 2000; Farkas et

al., 2005; Sheperd, Boardman, & Burns, 2010). These require a change of culture that involves a rearranging of power relations, and a move away from an exclusive focus on illness towards a focus on positive health. It also includes numerous practical organizational changes such as routines for information to enhance choices, employment of peer support workers and the establishment of physical facilities shared by both staff and users (Farkas et al., 2005). However, there are still challenges for the successful implementation of recovery-oriented service provisions (Slade, Adams, & O'Hagan, 2012; Tse et al., 2016).

Music Therapy in Recovery

Different definitions of music therapy exist, and vary in relation to which significant features, theoretical perspectives, and values are emphasized. Ruud very broadly defined music therapy as “an effort to increase peoples’ possibilities for action” (1998, p. 3), a definition that corresponds well with recovery perspectives. Recovery has been introduced in the music therapy discourse by several authors during the past decade (Ansdell & DeNora, 2016; Eyre, 2013; Hense & McFerran, 2017; McCaffrey, Edwards, & Fannon, 2011; Silverman, 2015; Solli, Rolvsjord, & Borg, 2013). As emphasized by several authors (Ansdell & DeNora, 2016; Grocke, Bloch, & Castle, 2008; McCaffrey, Edwards, & Fannon, 2011; Solli, Rolvsjord, & Borg, 2013;), the recovery perspective in music therapy draws upon perspectives that are critical toward the adoption of the medical model in music therapy, and instead emphasizes user involvement, the fostering of strengths and resources, and community orientation (e.g. Aigen, 2005; Ansdell, 2014; Procter, 2001; Rolvsjord, 2010; 2013; Ruud, 2010; Stige, 2002; Stige & Aaroe, 2011).. Some texts are, however, more closely aligned with consumerist-perspectives (welfare markets ideology) and psychoeducative perspectives (Eyre, 2013; Silverman, 2015; 2016). Thus, within music therapy there are differences in the understanding of the implications of recovery-oriented

service provision that mirror variations in the broader context of recovery literature (Pilgrim & McCranie, 2013).

First-hand narratives on music in a personal recovery process is presented by Sharma (2014) and Lewis (2017). Several studies of service users' experiences in music therapy have accentuated the potential of music therapy in terms of supporting clients' processes of recovery (Hense & McFerran, 2017; Hense, McFerran, & McGorry, 2014; McCaffrey, 2017; McCaffrey & Edwards, 2016; Solli & Rolvsjord, 2015; Solli, Rolvsjord, & Borg, 2013;). A meta-synthesis of qualitative studies of users' experiences (Solli, Rolvsjord, & Borg, 2013) conclude that music therapy offers "an arena for broadening and developing strengths and resources that contribute to growth of a positive identity and hope for people with mental illness" (p. 266). Other studies also emphasize the flexibility of music therapeutic practices as a potential resource in everyday life contexts (Rolvsjord, 2013; Solli, 2015). In an extensive longitudinal ethnographic study, Ansdell and DeNora (2016) describe musical pathways people with mental health problems use towards wellness across experiences of music therapy and uses of music in every day life contexts.

Methodology

This study focuses on the implementation of music therapy in a recovery-oriented unit of a community mental health care institution. In approaching implementation, a contextual and practice-oriented strategy was adopted (Peters, Tran & Adam, 2003) to explore the role and interactions of music therapy as part of service provision on the unit. Initially, a small group, including the primary researcher, the music therapist and a specialist in clinical psychology with responsibility for the strategic development of the ward, met to discuss the focus and design of the study. One pertinent theme for this group was how to involve users in the study

in a way that would be flexible and empowering. Initially, we also decided not to include policy makers and managers in the study, but instead focus on the interdisciplinary collaborations across various treatments, as well as the open spaces where staff and users informally meet. In designing the study, we chose an explorative design that could potentially point towards more specific areas for future research.

The context of this study is a recovery-oriented unit within a publicly funded community mental health institution. The unit offers structured day treatment as well as outpatient services. Clients on the unit are primarily experiencing psychotic illness or psychotic episodes. Typically, clients are between 18-30 years old. Total length of treatment is normally 2-5 years. The treatment services provided on the unit include a range of treatments and activities that clients can choose among. These include individual psychotherapy, illness management groups, family therapy, physical activity groups, problem-solving groups, social skills groups, arts therapy, and music therapy. Services are provided by an interdisciplinary group of staff including psychiatrists, psychologists, nurses, social workers, physical therapists, a job specialist, art therapist, music therapist and an employed expert by experience. A special team exists on the unit to provide services for “younger” users who are experiencing psychosis for the first time.

The unit is organized to support personal processes of recovery, which includes consideration of the structural organization of the unit. There are open spaces for users and staff, where they all meet for informal talks and coffee or lunch, in addition to having the possibility to congregate during the daytime. Treatment plans are made in collaboration with the users. They strive towards individualized treatment, and the professional teams are organized and collaborate with and around each user.

The music therapist has an 80% position and is primarily located on this unit. The music therapist is further integrated into all staff meetings, and is part of the professional team collaborating with the users he works with. The role and responsibilities that the music therapist has can vary with regard to specific clients, but such responsibilities do not include carrying primary responsibility for coordinating the assessment, treatments and case management related to an interdisciplinary team's support of a client. Music therapy is provided in a dedicated room equipped with a variety of instruments and music technology. Most sessions are provided in individual formats. The music therapist describes her/his work in terms of a typical Norwegian humanistic, resource-oriented approach (Ruud, 2010; Rolvsjord, 2010), and specifically emphasizes the acknowledgement of the clients' musical identities and the fostering of strengths and potential. The music therapist most commonly invites the users to engage in active music making, such as singing, playing instruments, improvising, recording or composing music. The music therapist has strong competence in popular and rock music idioms, and uses music technology as a resource in the interaction with clients.

A focus group design was chosen for this explorative study in order to take in multiple perspectives (Malterud, 2012; Wilkinson, 2008). In doing this, the study aligns with a *multiple perspectives paradigm* by integrating various perspectives, knowers and types of research evidence (Rose, Thornicraft, & Slade, 2006). An additional aim of using focus groups was to foster dialogues that could promote successful implementation of music therapy on the unit. The main inclusion criteria for participation were: a) A connection to the unit (as employee or user), and b) Experience with music therapy (in collaboration with the

music therapist or knowledge about the music therapy services offered in the unit). There were no further requirements regarding the amount of experiences that each person had with music therapy. The selection of participants can be described as purposive (Patton, 2002), in that we were searching for participants who had a story to tell about their experience with music therapy, and who could contribute with rich information. Taken together, the participants represented a broad variety of roles, responsibilities and experiences in the ward in accordance with principles of maximum variation (Patton, 2002).

Two focus groups were established, one group with participants with user experience and one group with staff. By conducting two separate focus groups, some level of homogeneity within each of the groups was thought to enhance a constructive dialogue (Malterud, 2012). In particular, we wanted to assure that the participating users' voices would not be limited due to power relations between an interdisciplinary group of staff and users, and that they would feel more confident and safe in a smaller group. Moreover, the two groups could potentially provide complementary perspectives.

The user group had three participants, one man and two women. Two of the participants had first-hand experience with music therapy on the unit, while one was an employed expert by experience who had second-hand knowledge about music therapy on the unit. The employed expert by experience was included in the user group, both because of her/his extensive contact with users at the center, but also because her/his participation in this group could support the other two participants. The staff group had five participants, and we selected participants from the interdisciplinary team who had some experience with the music therapy offered, and/or were engaged in collaborations with the music therapist. We sought variations in roles and professions among the participants, and therefore the group included two psychologists (specialists in clinical psychology), one nurse, one psychiatrist and the music therapist.

Two research interviews were conducted per group with approximately one month between the first and second interview. All four interviews lasted for approximately 90 minutes. The interviews with both groups were moderated by the primary researcher and author of this article. The music therapist at on the unit helped to organize the groups, and was also a participant in the staff group. One shared interview guide was used for both of the focus groups in accordance with a strategy of semi-structured interviews (Kvale & Brinkman, 2009). The interview guide intended to foster conversations about experiences of music therapy, how music therapy interacts with other treatments and activities, and the relevance of music therapy in this recovery-oriented context.

Data analysis was approached by combining a hermeneutic strategy (Kvale & Brinkmann, 2009) with content analysis (Ryen, 2002; Miles & Huberman, 1994). The interviews were transcribed verbatim. The transcribed data material was coded, ascribing open coding to every meaning unit of the interviews. The analytical software Atlas/ti was used in the process of coding, as well as in the following process of assigning codes to code families that identified the primary categories. The empirical material from both user groups and staff groups was considered of equal importance in the analysis. The analytic process included systematic searches for both similarities and differences between the meaning construction within the two focus groups, through an alternation of horizontal (across focus groups) and vertical (uniqueness of each focus group) analysis. This allowed for continuous engagement with the different parts of the data (two focus groups) to explore complementarity, add nuances and provide thick descriptions (Kvale, & Brinkmann, 2009; Ryen, 2002).

The project was approved by the Norwegian Centre for Research Data (NSD). The focus group in this case study included participants with a variety of roles, competencies and education, thus necessitating reflections on power relations that may come into play. The decisions of having two research groups was made to limit the implications of such power

relations, and also to make participation in the groups as safe as possible for the user/expert of experience participants. This choice might be considered somewhat in conflict with the collaborative and inclusive strategies that are encouraged in recovery-perspectives. However, in the analytic process, and also in the writing and representation of the data material, the equality of various voices was a main concern of reflexivity. Specific considerations were necessary to balance representation of the various participants in the user group, where participants varied greatly in terms of their level of verbal expression. A meeting with the user groups was arranged to keep them informed of the process of data analysis, provide a means of member checking and allow for the participants to give feedback on the representations of their voices in the final document.

Findings

The data analysis identified three main themes related to how service users and staff experienced music therapy as part of recovery-oriented service provision. The first category of findings is descriptive of experiences in music therapy and thoughts about how it was helpful for users in terms of their personal process of recovery. The second category of findings illuminates perceptions of what was experienced as unique or distinctive in music therapy compared to other types of services on the unit. The third category comprised experiences of how music therapy supports other parts of the treatment provision on the unit. In the presentation of the findings, the text is structured so that user perspectives are presented first.

Table 1: Taxonomy of findings

What music therapy does in support of personal recovery:	Fosters positive emotions and well-being Provides experiences of being capable Enables regaining identity and sense of self Provides experiences of social relating
What music therapy adds to the overall service provision:	A creative activity A different mode of expressing and relating A resource-oriented alternative
How music therapy interacts with other elements of the service provision:	Preparing emotional availability Enhancing general communicability Motivating for other treatment

What Music Therapy Does in Support of Personal Recovery

Music therapy was described by the users as something that was generally linked to positive experiences that they found helpful in terms of their process of recovery. The users provided rich descriptions of experiences of well-being, of how involvement with music provided experiences of having a capability, of how they felt music therapy stimulated their self-experience and about how music therapy involved experiences of mutual relationship and enhanced social contact and communication. The staff group provided second-hand perspectives to this, in terms of observations of how users made use of music therapy, in addition to examples of how users talked to them about their experiences in music therapy.

Music therapy fosters positive emotions and well-being. One very prominent aspect of how both focus groups described music therapy as helpful was that music therapy was linked to positive emotions and a sense of well-being. Still, this did not imply that they always felt good in the sessions, as the engagement with music would involve a spectrum of feelings. However, the users emphasized the capacity to brighten up their moods, and that they regularly felt better upon leaving music therapy than when they started the session:

UP3: Music is good. Music therapy works because music is good. Music feels good,

and I think things have to get better in one way or another when you spend time with something that feels good.

UP1: I think it's a lot about that feeling... that when you leave you are not feeling exhausted, stressed or sad again.

UP3: I always feel more up to things, a bit more awake, a bit better – when I walk out of the music therapy session

The staff group had also similarly observed how music therapy was linked to positive experiences, and provided moments of joy and pleasure for the participants:

SP3: But I see that it works, I see they get happy and so on.

SP2: I think it's a lot about the expectations they have for music therapy. They expect to go there to play music and to have fun in a way.

Music therapy provides experiences of being capable. Experiences of capability were prominent in the conversations in both focus groups. The users talked about music therapy as a place where they were asked about what they can do and what they want to achieve. The users experienced music therapy as a space for continued involvement with music, using their previous engagement with music as a starting point that helped them move forward with music. Mental illness could sometimes be a barrier to their engagement with music, and the users experienced being overwhelmed by emotional distress or performance anxiety when attempting to engage with music. Thus, music therapy helped them re-engage with music. Experiences of learning and of achievements in music were also described as useful for a more general belief in their own capacity to learn and cope:

UP3: One year ago I did not play music every day. I had kind of stopped doing that.

So music therapy has been a starting point for my development and for music as well.

UP1: I think there is something about getting an opportunity to learn, you know?

When you find yourself in a situation where you don't feel you are totally inept.

UP2: Yes, and if you learn something new, then maybe you can manage to learn other things as well....

The staff group linked the importance of experiences of being capable to possibilities to stimulate interests and previously acquired skills in music. Nonetheless, they also suggested that experiences of capability could more broadly enhance a sense of coping. The group emphasized the therapeutic importance of such experiences with regard to the hopelessness and failure often experienced by people suffering from mental health problems:

SP4: ...that feeling of hopelessness, of not managing anything. At the least, music therapy helps them get back to the feeling that they can manage something.

In the continued discussions by the staff group, the participants gradually identified a process of increased motivation, of initiatives and of the ability to conclude something as being interwoven with the experiences provided in music therapy:

SP3: What is very common in the beginning – like whether they are uncertain of what this (music therapy) is, and I ask: “What would you like to do?” “No, I don't know.”

So I am always searching for a way to get in. Often, I use listening to music when I first meet with a patient: “What (music) do you like?” “I like this.” “Ok, then let's start with that.” A bit back and forth....And then suddenly it happens – “I would like to play that song.” And that is just what I am searching for, some initiatives, something to move forward with. And what I notice with those who have been coming for a while is that they arrive with a plan – “ This is what I want to do...”

SP1: What you describe there is of the utmost importance. You work with some of the same things that we all try to work with, without always putting words to that? Both the ability to pull through, initiatives, capability...these are all fundamental problems here.

Music therapy enables regaining identity and sense of self . In the user focus group, the participants elaborated on various ways in which engagement with music in music therapy enhanced self-experiences and enabled them to regain a sense of identity . The users talked about how music therapy enhanced a variety of self-experiences that included a sense of clarity of thoughts, contact with feelings and bodily experiences:

UP3: ... I have become better with talking....I don't mess up the words that much ...haha..it is like oil for my brain to play music.

UP2: Some of the music that I like is almost violent, on the verge of being violent. But I hope that is not telling something about me....it is better to listen to war music than to go to war.

UP3: To me, it's about feeling/knowing the sound of your own voice. Then you know who you are and where you are.

The users describe how illness had affected their sense of self and identity. One of the users beautifully described her experiences in music therapy in terms of finding a way back to herself:

UP3: In a way, music therapy has been about finding myself again. Because when I was ill, I felt like I was gone. Well, I am not yet all well again, but I am better. I am a lot better because I recognize myself again.

The theme of regaining identity and sense of self was not equally prominent in the

discussions of the staff group, probably because these experiences is at the chore subjective and less observable from a staff perspective. Even so, the staff group generally talked about musical identity as one important level of experience for participants in music therapy. The participants in the staff group observed how users aligned with a set of identity markers (possibly inspired by the music therapist's style) of being a musician:

SP5: We talked about this before, about dressing up a bit, in a cool way - to be a musician..[...] We observe a physical change with them in the way they dress when they are going to music therapy. That is such a nice little extra that is not just about the music, but about young people creating an identity.

Music therapy provides experiences of social relating. The final category of experiences of music therapy's helpfulness comprises experiences of social relating, of contact and of communication. This includes experiences of the relationship with the music therapist, experiences of music as a non-verbal type of contact and experiences of how music therapy is helpful for a general sense of communicability. It seems that the musical relating in music therapy offers a sense of equality that the users and staff recognized:

UP1: You said that you felt he (the music therapist) treated you with respect?

UP2: Yes, I was a bit surprised about that because I do not feel I deserve that.

UP3: Other times you almost feel like your lose your humanity. But if you create art, or whatever – some music, then you are just human for a while.

UP1: Yes you are.

UP3: And then it is like humans are just humans for a while, and there are no differences.

In both focus groups, the participants pointed towards music therapy as a way to enhance contact and communication – also beyond that of musical interactions in music therapy. The music therapist described his experience of enhanced contact and social initiative:

SP3: I have seen them change from (demonstrates a depressed bodily position) to this (straightens up his bodily position), with eye contact and managing to be in contact.

And then it's at a different level, then we communicate like ordinary people if you see what I mean? And...I notice that they behave differently in contact with others on the ward, and have more eye contact and things like that.

One of the user participants describes how music therapy has helped her to be more open for social contact, and she describes how the experience of being able to communicate with other people enhanced her social communication in other arenas:

UP3: I have gained more confidence that people will understand me better when I talk with them. So, even if I sometimes doubt it, it has improved....It is not just about seeing myself differently, but having a different attitude to other people. Because they used to scare my ass off before...haha.

What Music Therapy Adds to the Overall Service Provision.

In general, in the context of the other activities the hospital music therapy was experienced as something that fit well into the recovery-oriented service provision on the unit. Music therapy is experienced as something that stands out as unique among the treatments and other activities offered on the unit. Thus, it is described as something that adds to, and complements, the other treatments and activities.

Adding a creative activity. The participants in the user group emphasize that the needs and interests of the users of mental health service provisions are very different. It is therefore important to have a broad variability in the types of activities and therapies offered. In particular, this user group emphasized the importance of creative activities and therapies to complement the otherwise verbal-oriented therapies, and also to complement the other activities on the ward and provide alternatives for users who could not make use of physical activities.

UP3: It's about meeting people as humans, and people function differently and think differently....For example, I do not think in words. Maybe there are others who also do not think in words, so then perhaps sitting down to talk with words is not the easiest way to get ahold of something. I believe in doing things more individually, and I think music therapy is one way of doing that.

One of the informants in the user group feels that the possibility to make sounds during music therapy adds something new that also differs from the other creative possibilities offered on the ward:

UP3: To have the possibility to make sound without anyone looking angrily at you. [...] It was very nice to be allowed to make sounds. And actually, for myself I have always thought that it has been therapeutic. But making sounds has not been tolerated, because someone might get scared.

The users described music therapy as something active, something that can complement the possibilities to engage with other creative activities (such as visual arts therapy) and with physical activity. With this focus on the “active doing” aspect of music therapy experienced by the users, music therapy enjoys a somewhat mixed status on the ward. Music therapy is experienced as something in-between an “activity” and a “therapy”. The staff group seemed to share such an understanding, as they made a clear distinction between music therapy and

psychotherapy. However, the staff group emphasized that music might be more useful than verbal psychotherapy for some persons:

SP1: Of course there is always someone who does not want psychotherapy, and we think that's ok because everybody is not supposed to have that. Music is nice, and maybe a better for those...yes.

A different mode of expressing and relating

The user group emphasized how music therapy is distinctive from other treatments because of the non-verbal and musical mode of expression. They suggest that for some people music makes them feel more at ease with expressing themselves, and that they feel more comfortable expressing themselves and their emotions through music than through verbal language. Using music also seems to be valued because they then feel free not to formulate themselves verbally, which is sometimes experienced as quite demanding. Conversely, when expressing themselves musically within music therapy, they feel they can approach a dialogue (musical or verbal) in a more natural way without any pressure to talk.

UP1: That you don't have to use words all the time, in other treatments you must talk about things repeatedlybut here you can feel things without having to talk about it and think about (it).....

UP3: It is more indirect – it just happens naturally in music therapy – instead of sitting down (to do that)Normal sessions with a psychologist are like dissections in comparison.

The use of music in music therapy also seems to create a relationship in music that is experienced as unique compared to other forms of relating on the unit. When making music together with the music therapist, they feel more like an equal human being, a fellow musician, than a patient meeting with a therapist.

UP3: It is perhaps also that it's something both active and interactive. If you make music with the music therapist, then you just make music. I feel it is like you are no longer a music therapist and a patient anymore, you are simply two people making music together.

One of the participants in the staff focus group reflects on how the experiences of musical relating may be somewhat in contrast to the other experiences in the context of mental health care, which might be more laden with unequal power:

SP5: Considering the differences that patients are very aware of – that I come to see the chief medical doctor or I come to see the psychologist. They experience some asymmetry to their own situation. They have not done that level of education....all those things come between people.

A resource-oriented alternative. One very prominent aspect of the complementary and unique feature of music therapy is that it is understood as a resource-oriented alternative. Even within the recovery-oriented ward, the qualities linked to the positive and strength-based focus in music therapy are perceived as distinctive. Music therapy gives a break from a focus on illness and problems for the users, and also differs from other therapies by stimulating positive emotions in contrast to other therapies they experienced.

UP3: I think that...music therapy is the first form of therapy where I have been asked about what I can do, and what I achieve.

UP3: And it's treatment with a positive focus in contrast with...in my experience all other treatment has been focused on "identifying and solving problems".

UP1: Other treatment is quite exhausting, and it does not give you such a positive feeling when you leave the session.

Also in the staff group, the distinctive resource-oriented feature of music therapy was outlined, and seen as an important complement to the other treatment offers.

SP1: Instead of thinking pathology and illness, that we direct the treatment to the illness or those traits that are problematic, I think music therapy might bring about surprises more in line with thinking about resources.

SP5: I think it fits in very well. It helps us to see other things, to focus on those healthy parts that can get even better, resourceful parts, creative parts. As you said, this is a bit in contrast to the more serious things we are formally set to deal with.

How Music Therapy Interacts With Other Elements of the Service Provision

During the interviews, music therapy was talked about in an interaction with a variety of contexts, but in particular discussed in relation to verbal therapy, visual arts therapy, physical activity, and with the more informal contexts of the open spaces on the unit, in particular an area referred to as “the launch”, an area in the middle of the unit where both staff and users meet while waiting for sessions, having a cup coffee or eating lunch. With the previous category, music therapy was experienced as adding something in terms of being complementary to other treatments and activities on the units. Nevertheless, the focus groups also outlined interactions in which music therapy was experienced as supporting other treatment contexts. As expressed by one of the participants in the staff group – this was somewhat in contrast to initial concerns that music therapy could potentially cause clients to avoid the more confrontational therapies:

SP1: I kind of thought that they might reject the more demanding and confrontational forms of treatment, but that has not happened, really. I think it has instead strengthened it.

However, both users and staff shared a general concern that the total amount of therapy sessions and activities would be too much for some clients if they chose to combine several of the services offered.

Three aspects of how music therapy is experienced as supporting other treatments were identified in the data analysis: availability, communicability and motivation. The accounts of these aspects were specifically present in the staff focus group, but also align with users' accounts of their more general experiences with how music therapy is helpful.

Availability for treatment. One of the prominent aspects described in the users' accounts of their experiences in music therapy was that they described feeling better after a session of music therapy. The staff noted this on various occasions, and realized that this was a potential resource for other treatment. One concrete example mentioned was linked to interactions between music therapy and CBT sessions. The music therapist and the psychologist both had sessions with the same user, and the psychologist noticed a difference when the client came to his/her sessions directly from music therapy. As a result, the psychologist found it was more useful to schedule the sessions of CBT after the sessions of music therapy.

SP2: Usually, when he did not have music therapy first he was leaden, and...it was hard to get anything out of him. But when he had music therapy he was very different, then he would have more energy and was more ready to talk with me.

The staff group did not conclude that this had any impact on the outcome of the verbal therapies; rather, they noticed that the mood changes could be potentially useful for their own therapeutic interactions with the users. The music therapist also suggests that music therapy can sometimes be a starting point for clients' contact with the unit:

SP3: If some patient has only been coming for me (music therapy), then we can carefully try to log on to other things. For example, some participate in physical

activity just after, or they go to talk with a psychologist or nurse afterwards.....so we try to combine a bit like that, since they are already on to it.

Enhancing communicability. In the user focus group, I directly asked one participant whether she/he experienced interactions between music therapy and verbal psychotherapy. The answer refers back to the experiences of music therapy as helpful for social relating:

UP3: Not directly, because they are not connected. But as I said before, it has helped me to communicate with people in general. So it has been easier to communicate with the psychotherapist, as well as with other people.

A general sense of communicability was also noticed by the staff, and they describe examples of how music therapy might have contributed to an enhanced communicability in other contexts.

The psychiatrist also reports episodes of enhanced communication in her/his session:

SP4: More lately, when I have been in contact with her/him, there has been a small amount of progress. But there is something that music therapy is doing, something that I cannot do in my sessions by simply talking with him. What he/she tells me seems to help her/him to calm down in telling me about her/his experiences; she/he has an urge to communicate a positive feeling....that he/she has managed something in music therapy.

Music also provided new chances for contact with users in the open spaces, “the launch” on the unit:

SP2: In those informal settings, like when we sit outside in “the launch”, it can be a redemptive theme to talk about, because it is easy to talk about music, right? It is not scary to talk about it, and everybody can relate to it. So quite often there is a good atmosphere when we talk about music, and then we would sometimes play a song from our mobile phones, and yes.....

SP5: Our patients experience failure in many areas of life, so to have an interest in music and have knowledge about artists and talk about them.... ...And in this way, we are without any difference in authority. We can talk...I would almost say...talk together. And I think that is a very good thing. Music is about feelings and interests, and it's a very positive thing; it's about something other than monitoring the symptoms of psychosis and dealing with when things get bad. It is about creating something very positive.

Motivation for treatment. The staff positively noticed that for some of the users music therapy is the main contact with the unit. And even if music therapy is the only treatment they receive, this also implies a chance for the other therapists on the unit to start to build a relationship with them. Music therapy sometimes supports a more general motivation to come to the unit, which helps to build an alliance that makes it possible for the user to get into more regular contact with those on the unit.

SP2: And some of those who come for music therapy, they only see you and that is the only thing they manage. It's a sense of coping then, to relate to a form of treatment.

SP2: Many of them (the users) come a bit before their session, and stay for a while afterwards [...] So they use the session to get a bit familiar here, right?

SP5: My experience with music therapy is that I think I have seen in the processes of recovery that music therapy has been essential in order to get in contact, to build contact with the patients. Actually, the music therapist has been able to get in good contact with many young men. And then we have managed to get them into a

treatment programme, that is what I have especially noticed.

Discussion

The present study aimed to explore and gain new knowledge about the implementation of music therapy in recovery-oriented contexts of mental health care service provision. The main categories of findings document different facets of the potential of music therapy in this context as experienced by users and staff. While the first category “what music therapy does to support personal processes of recovery” more generally describes music as a potential resource in processes of recovery, the second and third category “what music therapy adds to the overall service provision” and “how music therapy interacts with other elements of the service provision”, detail aspects of how music therapy was experienced as an integrated part of the service provision. Such aspects most importantly add to previous research on music therapy in recovery by highlighting potentials of music therapy to contribute to the overall service provision.

The findings linked to the first category are consistent with previous studies that focus on users’ experiences with music therapy (Ansdell & Meehan, 2010; McCaffrey & Edwards, 2016; Solli & Rolvsjord, 2015; Solli, Rolvsjord & Borg, 2013). This study adds to these previous studies by including second-hand experiences through the voices of the staff. Not surprisingly, the users contributed with the most nuanced and elaborated descriptions on this theme. However, there was a clear consistency between experiences described by the two focus groups in this area of inquiry. The experiences identified can be viewed as processes promoting positive health and well-being, rather than the reduction of symptoms and improvement from ill health. Current theories about the recovery approach invite an understanding of well-being and recovery as intersecting (Slade, Oades, & Jarden, 2017), which implies a relevance of these experiences for personal recovery. The CHIME

framework further encompasses the experiences described by the participants in the present study. Following this, we may say that there is a good potential for music therapy to fit in with other forms of recovery-oriented service provision in support of users' personal processes of recovery, and to work towards goals and agendas shared by both users and other professionals in such contexts.

The findings linked to the second and third category provide knowledge about music therapy as an integrated part of the other services provided on the unit. There are no previous studies that explicitly explore such contextual dimensions of the implementation of music therapy in recovery-oriented mental health care contexts. Clearly, music therapy is perceived on the unit as a distinctive and unique type of therapy that seems to complement the other treatments available. Yet, even after a short period of time with music therapy integrated on the unit, music therapy was experienced as supporting the other treatments. Negative examples, in which music therapy had been in conflict with other treatments, were not documented in the data material, although this was specifically asked for in the interviews. However, both the staff and users mentioned potential conflicts in the sense that some users could experience that the total amount of therapies and activities were too much if they took part in several activities and therapies on the unit.

The findings therefore reflect a potential of music therapy to not only "fit in with" recovery-oriented service provision on the unit, but also a potential for music therapy to contribute to the implementation of an overall service provision that supports personal recovery. Here, the distinctive features experienced by the participants in this study are a key finding. This perceived uniqueness is coherent with previous studies that have highlighted users' experiences of music therapy as being distinctively different from other "treatments", in terms of being musical and offering a space where illness is not in focus (Ansdell & Meehan, 2010; McCaffrey, 2017; Rolvsjord, 2010; Solli & Rolvsjord, 2014). In this study, these

distinctive features of music therapy also seemed to be experienced as useful by the other staff, for example as they described that music therapy supported their own contact with users. Two aspects of this will be highlighted in the following discussion, the positive and resource-oriented focus, and the potential of musical relating for building equality in relationships.

In several previous studies of users experiences, positive emotions and a distinctive positive focus on wellness rather than illness has been highlighted (McCaffrey, 2017; Rolvsjord, 2010; Solli & Rolvsjord, 2015). Similarly, in the present study, when compared with other services, music therapy was perceived by users and staff as providing a distinctive resource-oriented alternative on the unit. Music therapy was perceived as an alternative that focused on users' strengths, and fostered positive emotions and contributed to a sense of well-being. In everyday life, as well as in therapy, music is associated with feelings and emotions that can enhance the regulation of negative emotions and arouse positive emotions such as joy, pleasure, interest and motivation (Västfjäll, Juslin, & Hartig, 2012). Engagement with music involves the potential for enablement and the use of musical skills, as competence and achievements in music are generally valued in social contexts and society (Clarke, Dibben, & Pitts, 2010; Procter, 2011). Such potential clearly also comes into play in a therapeutic engagement with music in music therapy, and pushes toward a positive and strength-oriented focus in therapeutic encounters. The development of resource-oriented/strength-based practices is highly relevant in establishing a recovery-oriented service provision (Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Davidson et al, 2007; Tse et al., 2016). Hence, as much as this is a potential in terms of a quality of the experience that can support the personal process of recovery for users, this might also imply a potential to contribute to the overall recovery orientation on the unit by moving the service provision in a strengths-based direction.

In line with findings in previous studies (Ansdell & Meehan 2010; McCaffrey, 2017; Rolvsjord, 2016), music therapy also seems to offer a distinctive potential for mutual and equal relations that can be considered relevant for recovery-oriented service provision. The users in particular emphasized the musical interplay with the music therapist in terms of an equal relationship between musicians. Borg and Kristiansen (2004) studied service-users' account of the most helpful relationships with professionals, finding that the most helpful relations as described by the users were those characterized by respect, empathy and a general person-to person investment. Moreover, the users outlined episodes in which the professionals stretched a bit out of their "professional box" as especially helpful. We may suggest that experiences of musical companionship (Ansdell, 2014) in music therapy might have some of this quality – something that is experienced as different from what therapists and clients normally do. The musical interactions seem to overrule the typical roles of both the client and therapist, and bring a different set of identities into play – namely that of fellow musicians. A change towards more equal relationships between users and professionals has been emphasized as crucial for the "recovery of services" (Topor, Borg, Giralmo & Davidson, 2011, p. 96). It is consequently worth noticing that the findings from the present study seem to indicate a potential of musically relating that goes beyond the therapeutic relationship in music therapy, and drifts into the more open spaces where users and staff talk about, and sometimes share, music with each other. This could indicate a potential for music therapy to contribute towards more equal relationship between users and staff on the unit.

The present study explored a single specific case of implementation of music therapy on a recovery-oriented unit. It might be considered a limitation that only one person provided the music therapy services on the unit. There are broad variations of personal styles in the provision of music therapy, and in collaboration within interdisciplinary teams that needs to be acknowledged. Generalizations from single cases can only be theoretical, as they

exemplify and provide thick descriptions that can potentially be transferred to other contexts. However, in terms of recovery-oriented practices, singular in-depth studies can be of specific relevance precisely because recovery is taking place in the social space of different persons in different contexts. Further studies of music therapy in recovery services should also include cross-contextual aspects of music therapy in interactions with contexts outside the service provision.

In Conclusion

The findings from this study provide documentation of the role of music therapy in personal processes of recovery, and as part of the recovery-oriented service provision at this specific unit as experienced by both users and staff. The findings confirm previous studies that identify music therapy as a potential resource in personal recovery. Furthermore, the findings suggest that music therapy positively interacts with and supports other types of therapeutic services on the unit. Taken together, these findings illustrate the potential of music therapy to contribute to moving the unit towards a recovery orientation, in which music therapy is experienced as a resource-oriented complement to other treatments.

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