

# Is there a role for music therapy in the recovery approach in mental health?

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## **Abstract**

The recovery approach in mental health care emphasises the importance of the service user leading a fulfilling, meaningful life beyond the limitations of illness or symptomatology. This approach to care is increasingly included as a central part of mental health policy and service provision in a number of countries including the UK and Ireland, to address the needs of people who have severe and enduring mental disorders. It is an autonomous, holistic and empowering way of working with individuals as they journey towards healing. Fundamental to this model is the relationship fostered between service users and health professionals. The recovery philosophy of care mirrors some of the core principles of music therapy, including the importance of the therapeutic relationship and the possibilities for change and growth within this. This paper explores the congruence between music therapy and the recovery approach by providing; 1. An overview of current published evidence for music therapy in mental health care, 2. A discussion of this psycho-social creative arts therapy intervention within the specialized area of recovery in psychiatry, and 3. Case vignettes to illustrate the application of this philosophy in music therapy work within a recovery service.

**Keywords** Music Therapy, Mental Health, Recovery

## **Introduction**

Recent and emerging discussion of the recovery approach has been welcomed within the music therapy literature (Kooij, 2009; Grocke, Castle, & Bloch, 2008; Chhina, 2004). This parallels an increase in support for the practice of recovery in mental health care from the service user, carer and service provider community worldwide as promoted by the International Initiative for Mental Health Leadership (IIMHL, 2010).

According to the American Music Therapy Association (AMTA, 2010) almost 19% of members practise in the area of mental health. This is similar to figures produced by the Association of Professional Music Therapists (APMT) in the UK where mental health related work accounts for the employment context of approximately 17% of members surveyed (2009). Given the substantial number of music therapists practising within this area it is timely to reflect upon the opportunities for the music therapy profession to develop greater expertise within the specialist area of mental health recovery.

### **Music therapy: The evidence**

The growing evidence base for music therapy in mental health care supports the development of the profession in modern day mental health services. A review of controlled studies concluded that music therapy is “a structured interaction that patients are able to use to participate successfully, manage some of their symptoms, and express feelings relating to their experiences” (Edwards, 2006, p. 33). Lin et al. (2011) reviewed almost 100 studies of music therapy and mental health and concluded that

...music as used by music therapists results in clinical improvement. We found no demonstrable evidence that simply listening to music had the same type of result. Therefore, it may be that a purposeful and professional design for delivering music, coupled with other factors (such as actually making music as part of therapy, or the

interaction with a therapist), will potentiate the therapeutic effectiveness of music (p. 43).

Music therapy is a proven beneficial intervention for people with enduring mental illness which may bring about improvements in social functioning, global state and mental state (Grocke, Castle, & Bloch, 2008). A systematic review of music therapy studies with patients who have schizophrenia or schizophrenia-like illnesses concluded that the music therapy intervention, in addition to standard care, could improve patient's global state (Gold, Heldal, Dahle & Wigram, 2005). Research into music therapy with mental health service users has demonstrated improved symptom scores among those randomised to music therapy, especially in general symptoms of schizophrenia (Talwar, et al., 2006).

The effectiveness of music therapy to reduce negative symptoms of schizophrenia has been examined. A randomized control trial showed music therapy increased patients' ability to converse with others, reduced their social isolation, and increased their level of interest in external events (Tang, Yao & Zheng, 1994). The guidelines of the National Institute for Clinical of Excellence (NICE) in the United Kingdom in relation to the treatment of schizophrenia stated that arts therapies are "the only interventions both psychological and pharmacological, to demonstrate consistent efficacy in the reduction of negative symptoms" and recommends that consideration be given to offering arts therapies to assist in promoting recovery (NICE, 2009, p. 205).

The increasing evidence of the benefits of music therapy that these outcome studies have provided is a driving force for developing music therapy services in the mental health sector. However, the psychodynamic and process oriented aspects of music therapy including its unique employment of arts based non-verbal media to process experiences and feelings can be overlooked when privileging outcome based studies that focus on symptom reduction.

Further exploration of an holistic approach to service development and evaluation is needed across many areas of mental health provision (Hewitt, 2007).

### **The recovery approach**

Described as an idea “whose time has come” (Shepherd, Boardman & Slade, 2008, p. 1) the recovery approach in mental health has become an underpinning feature of mental health policy and service in a number of countries (Shepherd et al., 2008). Based on principles that place the client and their lived experience at the heart of decision making about treatment and care, the recovery approach emphasises hope, meaningful activity and empowerment (Lloyd, Waghorn & Williams, 2008; Shepherd et al., 2008). “Belief that there is hope for a better life is a large part of the recovery orientation” (Lloyd et al., 2008, p. 325). Recovery responds to and includes service user perspectives on the value of hope and positive expectations as described by a service user attending a focus group evaluating perspectives in mental health provision:

. . . its almost as if you've got to fight against the system to struggle to survive and put your point across: ‘And this is what’s happening to me, do you understand me? do you know what I'm doing? do you know what I'm talking about? . . . A person's got to work through emotion. They've got to work through stress. They've got to be able to work through voices and things that are disturbing and destructive to their lives (participant response - Happell, 2008)

The recovery approach can be distinguished from what is described as clinical recovery “which implicitly assumes that, in the majority of cases, correct assessment and optimal treatment are sufficient to achieve full symptom remission. This, in turn, enables people to return, mostly without further assistance, to premorbid levels of community functioning.” (Lloyd et al., 2008 p. 322). The recovery approach recognises that much more than clinical symptom management or reduction is needed in supporting optimal care objectives for

individuals. As Davidson, Shahar, Lawless, Sells & Tondora (2006) suggest, recovery is positioned

...in contrast to the traditional deficit-based model derived from the clinical discipline of psychopathology, *recovery-oriented care* is described as eliciting, fleshing out, and cultivating the positive elements of a person's life—such as his or her assets, aspirations, hopes, and interests. (p. 151)

The recovery approach in mental health maps onto a wider perspective in mental health services that has proposed the inclusion of service user voices in reviews of existing programmes and approaches as well as future decision making in policy areas. In Australia for example, an existing policy that standardized outcome measures should be used across all mental health services nationally has been criticised for its failure to include services user voices in the evaluation process. Happell (2008) provided an opportunity for some of these voices to be heard through conducting focus groups with 16 service users and reporting these outcomes. The study explored multiple perspectives in addressing the meaning of recovery, and highlighted the core concept of hope that recovery endorses. As described by one respondent -

I think they [services] should have a belief in optimum recovery. I mean, they should look for the best possible outcome (participant response - Happell, 2008).

At the same time the central concept of hope has required broader elaboration. As Geoff Shepherd and colleagues noted:

This need not mean that in recovery services everyone must always remain 'hopeful' even in the face of what seem to be insurmountable practical problems. While it is true that recovery approaches do generally believe that the individual's hopes and dreams are often more important than professional judgements about what is 'realistic', they do not encourage naïve unrealism (Shepherd et al., 2008, p. 3).

## **Music therapy and the recovery model**

The NICE recommendations in relation to arts therapies offer an incentive for further reflection upon the applicability of music therapy within the recovery model of care.

Recovery acknowledges that each person's journey to wellness is unique and individual. By actively participating in treatment goals and plans people can assume a fulfilled life even when faced with the challenges of mental illness. Recovery promotes hope, positive self-image and identity, trust in self, meaning, relationships, personal resourcefulness, confidence, control and above all else it emphasizes that the voices of people with mental illness are to be heard and respected (Mental Health Commission, 2007).

These central tenets of recovery share some of the core beliefs that inform and support the work of music therapists worldwide. Qualified music therapy practitioners work from the principle that central to personal well-being is the need for relating in meaningful contact with others (Odell-Miller, 1995). Therefore it is timely to consider the possibilities the recovery model offers within music therapy practices internationally. Music therapy can support the call of modern mental health services to reorient towards a more person centred way of working by facilitating individuals' personal journeys while at the same time fostering respectful, empathic relationships between service users and providers (American Psychiatric Association, 2005; Department of Health and Children, 2006; Mental Health Commission, 2007).

Grocke et al. (2008) have suggested that music therapy is "closely aligned to the recovery model of psychiatric care in that its emphasis is on "strengths and resources"(p. 444). Common theoretical ground between recovery and music therapy can be found in descriptions of resource-oriented music therapy (Rolvsjord, 2010). This approach in music therapy focuses on "the clients resources, strengths and potentials, rather than primarily on problems and conflicts, and emphasises collaboration and equal relationships" (Gold et al.,

2005). Schwabe (2005) described resource-oriented psychotherapy in music therapy as an approach in which healthy resources are emphasised and rediscovered through active and reflective listening in music therapy. Rolvsjord (2010) proposed that resource oriented music therapy facilitates empowerment, and she distinguishes it from medical or psychoanalytical discourse. This also parallels the goals of the recovery approach that simply following the status quo is not enough to ensure quality care (Borg & Kristiansen, 2004).

In the related area of arts activities in mental health, recovery has been presented as facilitated through participation in art making describing it as a *strengths based* approach (Van Lith, Fenner & Schofield, 2010). The association of strengths based approaches with the recovery model is a recurring theme (Davidson et al. 2006; Grocke et al. 2008).

Having considered the framework for music therapy within recovery the following case reports illustrate the approach of a music therapist establishing her practice as a member of a recovery team in a mental health service. These cases exemplify how music therapy can realise some of the central themes of recovery by responding to the individual wishes and requests of people with enduring mental illness in a way that realises their personal choices, strengths and potentials so that they can reclaim control over their lives. These stories reveal “willingness and ability to shape services to the needs and preferences of each individual service user”, qualities that are essential to recovery-orientated model of care (Borg & Kristiansen, 2004, p. 493).

### **Case Report 1**

‘Ann’ is a 66 year old female who has a long history of depression and marked anxiety stemming back over the past forty years. She was introduced to music therapy over two years ago when she would occasionally attend a weekly open group in her local day centre. Her attendance was sporadic and her engagement was passive expressing her wish to

“just listen”. Ann often became emotionally overwhelmed and tearful during songs of a sentimental manner sometimes causing her to leave the room and not return.

Ann informed her key-worker that she was no longer going to attend the day centre as it was too difficult for her so a subsequent case review was scheduled with the view to looking at other ways Ann could be reengaged in a meaningful therapeutic program. It was agreed that Ann be referred to individual music therapy in an effort re-engage her whilst specifically addressing her poor perception of self and limited social functioning.

During music therapy assessment Ann expressed her pessimistic view of life describing herself as being shadowed by “a dark cloud” and having a constant feeling of unhappiness. She declined to play an instrument and doubted her ability to do so insisting that I play instead as she stated that I was “better at it”. She lacked motivation and answered questions in a monosyllabic fashion. Ann found it difficult to make song choices often requesting that I make them for her instead, something that I avoided doing by offering her encouragement and support to make them herself. Once again she expressed her wish to “just listen” to music yet, whilst listening to songs she made subtle and feeble responses by gently moving her lips in synchrony to lyrics without vocalising. This indicated Ann’s self-doubt and lack of belief in her abilities whilst also hinting to me that she had potential to assume more active participation and control over her environment.

Initial sessions with Ann addressed her lack of self-confidence by supporting her to make choices and to foster communication through discussion of themes as they arose in her selected lyrics. One song choice that Ann frequently made was that of *Home on the Range* (1870). When asked what she liked about the song she pondered over the words “where seldom is heard a discouraging word and the skies are not cloudy all day”. These words re-echoed and yet contrasted to her earlier description of having a dark cloud over her in

opposed to the blue skies described in this song. She requested the song *Eileen McManus* (n.d.) about a young woman who leaves Ireland to work abroad. The girl featured in the song reminded Ann of herself as a young woman leaving her home in Ireland to seek a better life in the USA.

At review it was noted that Ann was arriving early and keeping all her scheduled appointments. This was a marked improvement in attendance and social functioning which was also evidenced in her participation to other classes at the day centre. Ann remarked that she was “getting things done” for herself and her mood stabilised with tearful episodes being rare. Subsequent sessions introduced her to instrumental improvisation in order to involve her in a success orientated task. Her playing on the xylophone was timid and barely audible yet she giggled as she randomly hit notes across the full range of the instrument. Question-answer like play placed more demands on her initiation of and responses to music and gradually Ann’s musical responses held more decisive and assertive qualities about them until she built up her confidence to perform a duet rendition of one of her favourite songs *Country Roads* (1971). A re-emerging theme in music therapy treatment for Ann has been “being able to”.

## **Case Report 2**

‘Kevin’ is 40 years old and has a diagnosis of paranoid schizophrenia. He first presented to mental health services at 24 years of age and since then has had seven recurrent admissions with severe episodes of self harm behaviour and pronounced cycles of depression, mania and aggression. He resides in a high support continuing care unit for people with severe and enduring mental health needs. Kevin was referred to music therapy for emotional expression by his psychiatrist after having psychotic episodes where he engaged in serious self-injurious behaviour and physical harm towards others.

Kevin's first session started with a discussion around his musical likes and dislikes. He mainly replied to questions in a monosyllabic manner and appeared ambivalent to the process at hand until he made a reference to his interest in sport and Ireland's defeat in a recent rugby match. I offered a musical response to his statement by playing *Ireland's Call* (1995) on the xylophone. With some encouragement Kevin reached for a percussion instrument and began to sound it resulting in a joint improvisation of the famous sporting anthem. This was the first of many 'real' musical encounters in Kevin's treatment.

In session four song composition was introduced to Kevin. He asked how this could be achieved so I explained that a first step could be to choose a style of music he would like to use. He hesitated initially and then said that he liked reggae, particularly Bob Marley. I began to gently hum and strum the chords of the song *No woman no cry* (1974). Kevin nodded agreement and said that that was the style he wanted. Deciding the lyrics was somewhat more difficult so I made the suggestion of re-writing the lyrics of this selected song whilst keeping the original melody. Once again I strummed the song's chordal pattern as Kevin made suggestions of lyrics similar to the original rhythmic pattern. After approximately 10 minutes Kevin had written a song.

The sun is shining today

Yet in my heart I'm grey

The sun is shining today

Yet in my heart I'm grey

In my youth my life goes by

And so I lay down and sigh

Things are looking better

Then it begins to rain

No more sunshine for us

After singing his song Kevin told me that it was during his late teens that he began to have mental health difficulties which were particularly pronounced as he began his studies at university. He expressed remorse and sadness about how his actions affected others around him at this time and described the resulting losses which he experienced.

A number of months into his music therapy program Kevin experienced further psychotic episodes accompanied by self harm behaviour and he required acute care. Sessions were postponed and resumed two months later. Using musical interactions such as song selection, song singing and improvisation stimulated discussion and expression of feelings with Kevin being able to communicate how he felt during his psychotic episodes. He spoke of his experience of fleeting thoughts and apparent distortion of reality. For example he had heard people around him refer to “May day” which he interpreted to be a sign of distress when in fact it was in reference to the first day of the month of May, a day of significance in the Roman Catholic calendar. His insight improved with greater awareness of the consequences of his actions towards others when he had become violent. He also articulated his fear of meeting people he once knew and their attitude towards him as a result of his mental illness.

Kevin had told me that he had attended piano lessons during childhood but had not played to this standard in many years. Despite his difficulties in concentration he sometimes played the keyboard for short periods. Two months after his music therapy program was resumed he arrived to a session suggesting he play the keyboard and skilfully performed the introduction of the Led Zeppelin song *Stairway to Heaven* (1971). He proudly informed me this was something he had been working on for a while and had learned from ear. This marked a point in therapy where he captured a more active role and has since brought in recorded songs for me to listen to and help him arrange for keyboard. By reawakening his musicality Kevin has

been able demonstrate self-determination. These outcomes underline the importance of finding and maintaining hope, re-establishing a positive identity, building a meaningful life and taking responsibility and control during the personal journey of recovery (Shepherd, Boardman & Slade, 2007).

### **Case Report 3**

‘Joe’ self-referred to music therapy because he wanted to learn a new skill to improve his self-confidence. During his first session he described his experience of living with psychosis and social anxiety and when asked how he envisaged music therapy to help him he exclaimed “music makes me feel good”. The following outlines the initial three months of weekly sessions.

Joe purchased a piano accordion and clearly expressed his wish to be able to play this instrument. In anticipation of sessions he had independently learned part of one tune. He had attended a music skills group in the past as part of a previous treatment program. Now being part of any group made him nervous and he had minimal social involvement. His fear precipitated sensory hallucinations whereby he believed that he omitted an unpleasant body odour which others could smell. His anxiety upon meeting new social situations and entering the building where sessions took place was evident and Joe often complained of stomach pains in the sessions’ opening moments. This translated into his playing which displayed considerable music skill but was unstable in metre, phrasing and dynamics leaving Joe dissatisfied with the final musical product. Notwithstanding this Joe eagerly continued to bring some of his favourite tunes to learn and acknowledged that he wasn’t attending for lessons but rather he wished to do something to help himself.

Joe tended to approach playing in a complex manner and was most self critical of his musical contributions. This only increased his anxiety and hurried his eager nature to strive but in many ways set him up for failure rather than success. It also warranted my sometimes

harsh honesty with him when he chose musical material that was overly intricate and ambitious. Treatment focused foremost on Joe's wish to build a musical repertoire on piano accordion but also upon self regulation of anxiety through play.

Sessions began by Joe making a song selection which featured simple I-IV-V chord patterns which he could play on bass alongside my singing and slow vamping accompaniment on keyboard in order to emphasise metre. This was a way of grounding and stabilising the music to help regulate pulse and breathing so that Joe's initial anxiety was curbed after entering the building. He commented that this was an enjoyable exercise to begin with which helped to settle him into sessions and resulted in a satisfactory musical experience.

By breaking suitable tunes into simple parts and separating left and right hand play Joe was able to improve his musicianship and acknowledge the gains himself. After his fifth session when he managed to play both the melody and bass accompaniment of the popular Irish piece called *Sally Gardens* (1889) he once again said that music makes him feel good about himself.

From the onset of the program Joe began to play the accordion at home of his own accord. To help him self-regulate his anxiety independently whilst also developing his music skills he was given a CD featuring recordings of pieces with emphasised metre which he could play along with. Joe reported that this helped him and added that he was occasionally able to build up the confidence to play for his house mates. After three months Joe had built a repertoire, from memory, of four traditional Irish pieces which he could successfully play from beginning to end.

Joe's self-direction in his treatment highlights how an individual's motivation and interest can develop when they are central to their own care-planning process. This is

fundamental to the recovery philosophy of care. In music therapy he has achieved and governed his ambition to learn a new skill whilst being empowered to help himself.

## **Discussion**

Music therapy is uniquely placed to provide opportunities for clients who have difficulties in participating in therapeutic services and who find general social relating challenging. The review of studies pertaining to people who have severe and enduring mental illnesses recorded a “negligible” attrition level for participants (Grocke, et al., 2008, p. 444). In the experience of the authors, clients attending music therapy services do so regularly, and note that self-care frequently improves, with clients “dressing up” for sessions (Tommy Hayes, personal communication, 2008). Therefore, these aspects of potential benefits including self care and economic impact might be given consideration as a parameter for evaluation in future studies.

Music therapy focusses on the resources and strengths of clients; gently and gradually building their confidence and capacities through regular supportive sessions over time. While music making requires a unique kind of mental organisation that is difficult to account in simple terms, it is important to consider music’s distinctive capacity for the promotion of self-organisation and self-regulation. In conjunction with another person, playing music together mirrors all the capacities for relating that verbal interaction requires; including listening, responding, and initiation.

The case reports presented here provide support for the applicability of music therapy within the recovery approach. Processes in musical interaction that make therapeutic work by a qualified music therapist particularly relevant within the recovery model still require further examination. Further case reports and case series will be needed to stimulate consideration of mechanisms by which change occurs, optimal regularity of participation in order to achieve benefits, or how long changes are sustained after cessation of sessions.

## **Conclusion**

Three individuals with an enduring mental illness are described attending their first music therapy sessions, finding ways to build on their capacities through music, demonstrating new skills, and one of whom re-kindles a previous interest in music. Along the way they demonstrate interpersonal relating through initiation, listening, and responding. This process is guided expertly by the qualified music therapist being responsive, patient, non-directive, and verbally and musically supportive of the client's contributions.

These case reports of individuals show the potentials for music therapy as a supportive intervention able to meet clients at their level of functioning and build on strengths towards beneficial outcomes. This reflects some of the core principles of the recovery philosophy in mental health care. Further examination of the role of music therapy within the recovery model is warranted.

**Declaration of Interest:** None

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