A Philosophical Inquiry into Music Therapy, Adult Day Centers, and Serious Mental Illness

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ABSTRACT

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Sandra Tickner-Broadhurst

Music therapy is a discipline which has shown to be effective in empirical studies when its interventions are used in psychiatric hospital units or specialized psychiatric settings to: (a) enhance global well-being, (b) improve psycho-social functioning, (c) diminish anxiety, (d) decrease stress, and (e) support validation. The purpose of this inquiry stemmed from the author's assumption that music therapy may also assist older adults with serious mental illness experience a successful integration into an Adult Day Center. The research design used a philosophical inquiry methodology to investigate and develop an argument to support and present the potential roles of music therapy in assisting the target population make the transition/integration into the community service provider of an Adult Day Center. Development of the argument involved an investigation and analysis of the role of music therapy's potential as an essential first-line intervention towards facilitating a successful integration experience. Analysis of the literature demonstrated the efficacy of music therapy to enhance socialization, communication, recovery and well-being for adults with serious mental illness within psychiatric hospitals, day hospitals, community settings, and demonstrated the possibility of similar interventions in an Adult Day Center. The results revealed the potential for music therapy to be effective in the Adult Day Center setting to decrease: (a) the risks of isolation, and (b) the multi-faces of stigmatization, bias, and prejudice. Music therapy's potential for addressing non-adherence to health care services for older individuals with serious mental illness looks promising however, the current evidence is inconclusive thereby indicating need for further research. The conclusion addresses the limitations of the study, gaps in the literature, the author's interpretations of the inquiry, and presents potential future questions for practice and research in music therapy in Adult Day Centers.

Dedication

This work is dedicated to my daughter Lisa Alice Broadhurst-Duplisea, my best friend, my soul sister, my one true constant, the light of my life.

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When I was growing up in a very different era, the thought of a woman going to university was still considered inappropriate. She was supposed to stay home with the children and her husband, clean house, and take care of the family. This way of thinking never fit into my philosophy. However, throughout my childhood, teenage years, and into my early twenties the idea of attending university was no more than the unreachable star. As the first person in my family to have completed a Bachelor's degree, and now, at 60 years of age, completing this Master's is truly my brass ring achieved. I never let go of my dream and with perseverance, incredible sacrifices, passion, and with the grace of those who believed in me, I have finally reached my unreachable star. The following people walked this path of academia with me and I wish to take this opportunity to thank them.

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Chapter 1. Introduction

In theory, the golden years are equated with a time for relaxing and enjoying our senior years with friends and with family, or maybe just doing the things we have worked a lifetime to enjoy. In fact, the term golden years now has a very different meaning than it had only 30 years ago, (Barns, 2011; Statistics Canada, 2007). Sometimes known as The Third Age, the golden years have significantly changed due to a relatively new phenomenon, longer life spans. For the purpose of this study, the third age, or golden years, shall be designated as older adults and defined as the time span occurring between retirement and the beginning of age-imposed physical, emotional, and cognitive limitations, and roughly between the ages of 65 and 80 plus (Barnes, 2011).

Aging-related deficits, which represent moderate to large negative correlations with aging, begin to appear during early-adulthood in areas such as: (a) episodic memory, (b) spatial visualization, (c) processing speed, and (d) abstract reasoning (Barnes, 2011; Salthouse, 2009; Tucker-Drob, 2011). The most common and costly health care problems facing the older adults of today are chronic diseases, some of which may often be linked to lifestyle choices and at times could be prevented, lessened, or managed (Barnes, 2011). Adult Day Centers (ADC) under investigation in this inquiry predominantly focus their therapeutic health care programs and interventions with older adult populations as designated by the criteria within the Minister of Quebec (2005) mandate. Although these ADC's are directly linked to community health care services, the stipulated criteria for registration, and participation, may pose difficulties towards successfully accessing or integrating essential community health care to certain populations. The service-consumers examined within this inquiry are seniors diagnosed with serious mental illness (SMI).

The Diagnostic and Statistical Manual (DSM) is the most accepted document used to define various types of mental health illness in North America. However, when attempting to globally define serious mental illness finding a comprehensive and population accurate definition can be more challenging and complicated. For this reason, the author has chosen to use the definition retrieved from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS, 2015) due to its comprehensibility and clarity. Their definition clearly indicates SMI to be adults and who are individuals 18 years of age or older. (ODMHSAS, 2016). Under the ODMHSAS definition to be considered having an SMI, the individual must demonstrate a persistent disability of a duration of 6 months and/or longer with either psychotic symptoms or difficulties substantially limiting/interfering with a positive quality of life experience. These psychotic symptoms or difficulties include achieving or maintaining one or more developmentally appropriate: (a) social, (b) behavioral, (c) cognitive, (d) communicative, or (e) adaptive skills that repeatedly impair behavioral control, and self-care (ODMHSAS, 2015). These individuals are also identified as a unique population which underutilizes behavioral health care partially due to the high cost of health care in the United States (ODMHSAS, 2016). Although the ODMHSAS (2015) definition aids in clarifying serious mental illness (SMI) for adults 18 years and older, it does not address, with clarity, how the portrait of SMI changes for those 65-years and older. These individuals, when coping with the additional bio-psycho-affective concerns related to aging which adds and further complicates defining the senior with SMI. This is a specific area of psychiatry known as geriatric psychiatry, or psychogeriatrics.

The onslaught of age-related illness, co-morbidity, and enduring stigmatization upon pre-existing SMI diagnoses makes addressing health care requirements more complex than for those individuals without SMI. These complexities arise in both their existence and in their treatment/therapeutic intervention (Grock, Bloch, & Castle, 2009; Hayward & Bright, 1997; Statistics Canada, 2007; Weiss, 2012). Other important and potential barriers to successful health care intervention can be found within the bias of non-professionals (e.g., community, family) and professionals (e.g., doctors, care-givers affiliated with professional organizations or institutions), usually stemming from a fear of, or general lack of education and knowledge of the commonly presenting traits, or behaviors, demonstrated by individuals with SMI throughout the community at large (Baumann, 2007; Crisp, 2000; Currin, 2001; Elisha, Castle, & Hocking, 2006; Jones et al, 1984; Link & Phelon, 2001; Parliament of Canada, 2006; Stratford & Scott, 1986; World Health Association, 2002). Equally important and requiring improvement is the impact of the bio-psycho-affective behaviors which emerge from the secondary effects of long term pharmacology in the treatment of SMI. These effects can negatively impact the quality of life experience especially if misunderstood by non SMI community health care service-users. Some of these factors are the results of the impact of government cost-cutting (Action on Mental Illness Quebec, 2016; Parliament of Canada, 2006; Public Health Agency Canada, 2013; Statistics Canada, 2007). Empirical literature is easily accessible on the previously-mentioned barriers; this is not the case for the older adult with SMI. In fact, the empirical information is greatly limited when addressing the issue of successful transitition from institutional life to community life. In the current century adult day centers are just beginning to play a significant role in providing maintenance of health care services post-hospitalization, physically and psychologically. In order to better understand how, and why the barriers from institutional life into community ADC are challenging for the older SMI individual let us begin by looking at the mandate of an ADC.

Originally designed to provide respite care for the caregivers of children or adults with physical or mental disabilities, and still a relatively new entity, the ADC has been steadily evolving to become an essential part of the overall support system in providing community care for various populations. Throughout Canada in each of the provinces and territories a range of facility-based services within specific communities or regions has been developing. In Quebec the senior ADC is offered as an on-site service program provider for care recipients. Here seniors can participate in group activities tailored to their needs which are conducted by trained staff, students, and volunteers (Canadian Healthcare Association, 2012). A Senior ADC is a community resource for the senior 65-years or older providing the opportunity for the attendees to remain living at home/within the community while receiving bio-psycho-social services through the programs and activities offered (Action on Mental Illness Quebec, 2016; Minister of Quebec, 2005). The principal mental health network in Quebec directly linked to the ADCs includes the local community centers (known as CLSCs: local community services centres) that work to provide follow-up programs (Canadian Healthcare Association, 2012; Fleury, 2005).

The concept of an ADC is still young in its development, having been in existence for approximately 30 years. In 1974, in the United States of America, there were only 18 centers functioning. The 2001 survey presented by Partners in Care-giving put the number of adult day care centers at 3,493 nationwide. This same survey also indicated that at least twice as many centers are needed as are currently available. For the purpose of this inquiry the author was unable to retrieve statistics pertaining to Canadian ADC's up to an including the present date, however the National Adult Day Services Association estimates current numbers of adult day care providers at around 4,000 (Day, 2016).

The services provided by an ADC include prevention management, community health care information, and therapeutic activities focusing upon socialization, decreasing the risk of isolation, and enhancing global well-being. Consisting of a nurse, a social worker, orderlies, and other professionals from various disciplines, activities are generally offered in group settings. The admission requirements include motor, cognitive, sensorial, and/or mental health incapacities with referral for admission coming through other community health care service providers such as day hospitals, rehabilitation centers, doctors, social workers, psychologists and psychiatrists. All participants must have an open file within the CLSC to be granted admission. A major misconception of an ADC is it is a community center or golden age group. It is important to recognize an ADC as a health care service provider offering maintenance and support as second line community health care. For this reason, individuals diagnosed with SMI are granted admission only if one or more of the previously mentioned criteria are present (Minister of Quebec, 2005). The exclusion criteria into the ADC`s of the greater urban regions of Quebec are considered, and applied, to those individuals who present disruptive behaviors which are presumed to (possibly) interfere with the attainment of group objectives. The exclusion criteria can easily cause barriers to integration and possibly enhance bias simply by its existence. It should be noted the admission/exclusion criteria for individual ADC's throughout Canada and the United States is not covered by a blanket mandate, therefore, each ADC`s jurisdiction will have its own inclusion/exclusion criteria.

The nature of SMI includes: (a) impoverished social functioning (Elisha, Castle, & Hocking, 2006), (b) diminished communication skills, and (c) diminished or "at risk" coping skills (Skodol et al., 2002), meaning the risk of being declined admission into an ADC is elevated in comparison to those seeking admission without SMI symptoms. In this author's opinion, no individual should be declined admission to an ADC based solely upon the above-mentioned criteria for to do so is promoting bias and prejudice towards SMI, and is counter-indicated for the purpose of the existence of an ADC to provide community health care. She also feels strongly whenever necessary, a period of intervention to assist integration should be made available when a diagnosis of SMI is present especially during the beginning phase of participation in an ADC to diminish the possibility of non-adherence or non-participation within the service provider's activities.

Given that a literature review demonstrated music therapy to be an effective intervention in improving social functioning and well-being within in-patient psychiatric settings (Chhina, 2004; Eyre, 2011; Silverman, 2011a, b; Solli, Rolvsjord, & Borg, 2013) the author believes music therapy might also enhance, increase, and maintain social functioning and communication.

In most instances prior to returning to outpatient community services, the older individual`s SMI symptoms have been stabilized either in-hospital, or through the intervention of other specialized settings. To maintain this stability, the need for a successful integration into the offered programs of the ADC is very important towards maintaining well-being. When integration occurs and active, engaged participation in the bio-psycho-social programs of the ADC is adhered to, recovery through well-being has an increased possibility of occurring. The literature indicates maintaining adherence to the program and activities of an ADC is essential to well-being for seniors with SMI, and attrition or dropping out might be decreased as an outcome (Hannibal, Pederson, Hestbaek, Sorenesen, & Munk-Jorgensen, 2012; Johannson & Eklund, 2006), and given the results of in-hospital studies, it is plausible to assume music therapy might support a successful integration experience. Therapeutically speaking, we may even be able to assume that if the senior with SMI has already experienced music therapy in another in-patient setting, then using this familiar intervention may decrease some of the transition anxiety. With transition anxiety reduced the prospect of enhancing the integration process may then be improved. . However, if the senior with SMI is introduced to the regular ADC activities, where fitting in is derived from the notion of “Social Distance” (Baumann, 2007; Moran, 2009; Steinbach, 2004), defined as “the distance one wants to have between oneself and another in a social situation” (Baumann, p.132), the risk for dropping out of the program increases substantially due to stigma, bias, discrimination, and other factors (Weiss, 2012). This leads to the loss of continuity of services and possible rehospitalization, or worse, the increased risk of suicide. In the article entitled ‘‘*Mental Health of the Elderly’’* it is reported that 15 to 25 percent of elderly people in the United States of America suffer from significant symptoms of mental illness. Among this population, individuals 65 years and older have the highest rate of suicide. Sadly, only 1.5 percent of the direct cost of treating mental illness is spent on elderly people in the community (Mental Health Canada, 2016).

The population is aging, and the generation known as the Baby Boomers are beginning to seek health care services for age-related illness. Statistics Canada (2015) predicts that by 2036, the number of Canadian seniors will have doubled. Within the Boomer generation, the percentage of individuals with SMI is not decreasing and this suggests the necessity of being aware of the rapidly approaching demand for increased specialized services (United States Census Bureau, 2014). This awareness is needed on the part of service-users and the health care system. For example, at the time of this writing, in the large urban Quebec area where this author is employed, significant government funding cuts are resulting in the reorganization of programs within its 6-ADC sectors. The timing therefore seems perfect to make a case for the use of music therapy in assisting a successful integration process for seniors with SMI and to also argue for music therapy as a regular and essential service within ADCs.

Marshall et al.'s (2011) research indicated that acute day hospital/day treatment program care can be very effective in assisting the integration process into community based psychiatric care. There was however, one caveat regarding this finding: for those whose intervention needs are high, outpatient service is the most attractive; it is a less attractive option for those whose in-patient care is lower. Their results also indicated positive evidence that day treatment programs were superior for continuing outpatient care when intervention need requirements were lower. A second caveat of the study was that the positive results seemed to be due to the structured support given to the individual for improving psychiatric symptoms within the day treatment program.

Dependent upon the diagnosis, the age of onset may vary, however for most individuals the symptoms begin to manifest in early adulthood (American Psychiatric Association, 2013). Serious mental illness is life-changing and life-long. Insel (2013) explains for the adult with a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment, the possibility to participate in major life activities is substantially interfered with, or limited. When beginning participation in an ADC, those older adults with SMI face additional complications and barriers than the non-SMI senior. This can be attributed in some instances to stigmatization, bias, prejudice, and discrimination (Crisp, 2000; Elisha, Castle, & Hocking, 2006; Moran, 2009; Public Health Agency of Canada, 2006; Snowdon, 2003, Thornicroft, Rose & Kassan, 2007; Watson & Corrigan, 2013; Weiss, 2012). As individuals with SMI live in constant fear of an isolated and uncertain future (Gold, Solli, Kruger, & Lie, 2009; Hannabal, Persen, & Hestbaek, 2012), social and community service networks can play a very important role in enhancing and maintaining quality of life (Grocke, Bloch, & Castle, 2009). In Quebec, an ADC's mandate is to provide health care services and decrease social isolation (Minister of Quebec, 2005) in hopes of maintaining well-being for their participants. For those with SMI, decreasing the barriers may be complicated due to additional stigmatization stemming from professional care-providers, the social stigma from other participants, or both, thereby elevating the risk of non-adherence to health care services (Canada, Parliament Senate Report, 2006), or dropping-out of treatment thereby causing a breach in quality care (Snowdon, 2003).

Purpose of the Study

As expert documentation and studies indicating stigmatization and social isolation to important factors that block integration into community or social settings/activities, the purpose of this study was to inquire the role music therapy might play in assisting with the integration process for older adults with SMI when transitioning/integrating into a community ADC. The results stemming from the literature reviewed aspires to provide empirical evidence to support the argument how music therapy, if implemented as an essential service in community health care for those coping with SMI, has the possibility of enhancing adherence to health care service, and shows promise of aiding in decreasing the risk of dropping out of treatment programs.

The results from the literature reviewed is hoped to provide access to important literature for music therapists, allied professionals, and care-givers of the targeted population and to advocate for education towards understanding the needs of individuals with SMI, and the changing needs of this same population as they enter into their senior years along with the potential issues of co-morbidity associated with aging.

The Research Question

Originating from the author's personal relationship to, and observations in psychiatric and community settings the question as to why music therapy intervention might be considered one of the best ways to help older adults with SMI successfully integrate into a community ADC began to emerge. This primary question quickly led to the formulation of secondary questions as follows: 1) If music therapy were to be the first intervention group offered upon registration, would it assist in enhancing the integration process?; 2) Might this strengthen the possibility of a successful integration into an ADC when transferring from specialized psychiatric settings into community service settings?; 3) Might using music therapy as a first line group intervention assist in developing the necessary psycho-social coping skills to support adherence to participation thereby diminishing the risk of dropping out?; and 4) In a mixed music therapy group setting which includes participants with and without SMI, might the opportunity of developing healthy interpersonal relationships be increased?

Personal Relationship to the Topic

Since 1998, after completing her music therapy internship, the author began to work with older adults in a large urban city in the province of Quebec. Her specialization in, and passion for, the population known clinically as psychogeriatric developed naturally over a 15-year period while employed in specialized psychiatric day hospitals and day centers. It was always such a joy to see the group participants experiencing pleasure and joy through the power of music in all its varied forms, clinical and social. In 2006, when she began to work with seniors in a community ADC this coincided with an influx of individuals previously receiving their health-care services in the specialized settings of the day hospital or psychiatric ADC, but due to the continued deinstitutionalization of psychiatric day centers and Bill 10, those same individuals were now being referred to the community ADC for follow-up and maintenance health care. She was deeply concerned as she noticed how easily they dropped out of treatment intervention because they had difficulty fitting into the social life of the ADC. Some of these individuals had previously been participants in her music therapy groups within the psychiatric day centers and hospitals. She knew them to be able to engage successfully and with enthusiasm, yet in this setting they simply stopped coming to the ADC shortly after registration. Although not statistically validated, the non-adherence was higher when first entry activity was within the larger social environment of recreational activities. The issue here lies within the need for capacity of basic and adequate psycho-social skills for a successful integration to occur in the social environment of these activities. However, in the music therapy groups offered, psycho-social coping skills can be learned through the non-verbal music therapy approach. Social distance (Baumann, 2007) appeared to be playing a role in the dilemma also leading to withdrawal and termination of participation. This became a major frustration to the author as the ADC was the essential service provider to this community. Being an empathic individual, the author began to look for ways to overcome this barrier to integration. This led her to ponder about music therapy as a means to address the problem of dropping out of the offered programs and the risk of attrition within an ADC. She began to reflect upon her work in music therapy, her clinical observations of the similarities and differences within in-hospital and community arenas, and how these reflections could be applied to assist the transition and integration process into the ADC for this targeted population. She began to openly advocate to her multi-disciplinary team her personal and clinical experiences with the population. It was truly here she became aware of lack of education in geriatric psychiatry pertaining to intervening when common SMI traits presented. However, the clincher came when advocating for a particular client with non-menacing social behaviours to remain in the ADC she became very frustrated when this client was to be removed from active participation due to the SMI traits this individual presented. The author considered this attitude to any individual, with or without SMI unacceptable, and suggested she assume this client in her music therapy group with a very successful outcome. That day, and that person, began the author's desire to work towards advocating for music therapy as an essential service and for positive SMI awareness. Believing within non-homogenous music therapy groups, (SMI and non-SMI together), a positive and pleasurable experience for the participants could enhanced socialization and validation within her music therapy groups, many questions began to surface. With so many questions beginning to emerge and with the author's convictions in the power of music as a healing tool, this study was born.

Definition of Key Terms

Language is important to provide meaning when sharing information. For that purpose, and especially to clearly define each key term within this philosophical inquiry, the following key term definitions are provided. *Adult Day Center* (ADC) is defined as a service provider whose role is to offer the participant who presents with a loss of autonomy the ability to continue to live within the community for as long a time as possible; a health service resource center for those who are registered participants living within the community. The ADC is a service provider which offers preventative, therapeutic, or rehabilitative programs and activities. The adult day center program addresses the individual 65-years or older living in their home (Minister of Quebec, 2005). Other terms used for this type of care service are: Adult day care, adult day centers, adult day care center, adult day health, adult day services, adult day health services, adult day residential care and medical adult day care services (Day, 2016). The term *Geriatric* stems from the science of medicine for the elderly, and its origins are Greek meaning: gér(ōn) old man + iatric or "old man" and "healer" (Farlex Partner Medical Dictionary, 2012). For the purpose of this study, the individual 65-years and older has been chosen to delimit the population considered geriatric or senior as most social institutions recognize age 65 as the "normal" age of retirement and as the age at which individuals are entitled to receive full pension benefits from Canada (Turcotte & Schellenbert, 2007). *Psychogeriatrics*, also known as *geriatric* *psychiatry*, geropsychiatry or psychiatry of old age is a psychiatric subspecialty which focuses upon the assessment, diagnosis and treatment of complex mental health disorders uniquely occurring in later life. This form of psychiatry focuses upon providing care for the intensive needs of the senior individual at a time when many physical and mental health issues coalesce (Canadian Academy of Geriatric Psychiatry, n.d). *Rehabilitation* within a mental health context refers to the services that are made available to individuals with a [serious] mental illness, with the targeted outcome being one which enables that individual to learn to adapt to their world (Chhina, 2004). Finally, *Stigma* for the purpose of this paper, is defined as a "negative stereotype" concerning mental health conditions resulting in negative consequences; how people "judge them is one of their greatest barriers to a complete and satisfying life" (Canadian Mental Health Association Ontario, 2015, para.2.).

Relevance to Music Therapy

A deeper and more profound understanding of this study's relevance to the profession of music therapy grew as the author's research progressed. As health care needs of the older adult can be more complex than the health care needs of older individuals progressing through the aging process without SMI, the benefits of traditional (verbal) therapies can be hindered due to the lack of efficient communication skills which predominate SMI. Music therapy's effectiveness as a non-verbal intervention method has been both recognized, and proven effective, in in-hospital settings, mostly in studies using individuals with schizophrenia. This study's examination of references and empirical studies can assist by providing educational insights into problem traits regularly observed in the SMI population. Although the focus of this study is upon music therapy in an ADC setting, and to provide practical knowledge of various music therapy intervention methods when working with a senior SMI population, it can equally assist and be applied when working with any SMI population. In so doing, the introduction to multi-disciplinary professionals of the potential effectiveness of using music therapy techniques may prove beneficial when health care service professionals find themselves unfamiliar or coping with the traits commonly seen in SMI known to impede or hinder access to (health) care. As isolation presented as a predominate theme in the SMI community and populations his inquiry provides explanations that may serve to contribute educational insights pertaining to the diminishing of barriers arising from stigma, bias, prejudice, and/or the misunderstanding of SMI traits which may also lead to non-adherence to treatment and maintenance of health care during the integration process.

As the study progressed it became evident there are many differences between ADCs in Canada, the United States of America, and other countries worldwide. Some focus upon dementia and Alzheimer's disease, others focus on rehabilitation. Some are categorized by age e.g. child, youth, adult, and senior. Some focus upon providing respite care while others are culturally or linguistically oriented. Some focus upon the specific care-giving needs of individuals such as occurs for individuals with Huntington's or Parkinson's disease. Equally diverse is the method of staffing an ADC. The common denominator between all ADCs is the client needs of the populations they serve. Staffing needs should meet the same criteria for effectiveness of the programs. This awareness caused the author consider the important role music therapy might be able to globally play within the diverse needs of an ADC. Some examples might be the manner in which music therapy could advocate for the need of specialized education for: (a) primary (family members or principle support or care-givers outside the health care system), (b) professional (doctors, social workers, nurses, physical therapists, occupational therapists), and (c) nonprofessional (orderlies, support companion) caregivers as a spontaneous or extended result of a positive outcome after an individual participates in music therapy. It is important to note what is considered an essential health care service varies from province to province in Canada (O'Grady & Roos, 2014). Subsequently, the literature retrieved for this study might permit consideration through presenting results to indicate music therapy intervention with the older adult SMI population in ADC's, and in psychiatric settings should be recognized as an essential health care service throughout all ADC's.

Stigma, although unintentional, may manifest from those unaccustomed to working with the SMI population. Other scenarios might include caregivers who, albeit unfamiliar to those unaccustomed to psychiatric illness, find themselves having to cope with the unfamiliar, or the uncomfortable behavior traits typical in SMI. Therefore, the relevance of this study may prove helpful in addressing, or becoming aware of, the existence of professional biases, prejudices, or the need for increasing education in ADC's related to the special needs of this particular population.

Chapter 2. Methodology

The design used for this study was philosophical inquiry as described by Kenneth Aigen (2005). The primary mode of inquiry used was the argument, and in this form of qualitative research, the sense of reasoning is key in order to fully explore the argument. The researcher must approach the subject matter from a deductive, an inductive, and a retroductive perspective. To achieve that purpose in this inquiry, the argument performed the function of philosophical thinking, and the inquiry audit helped to provide the results and conclusions. Approaching the analysis from the perspective of an opinion paper, the author identified the specific problems facing the population under study, and then analyzed, discussed, and presented arguments regarding the role of music therapy in enhancing ease of integration of older adults with SMI into the community milieu of an ADC.

Personal Assumptions

The author began this research with the assumption music therapy should be considered an essential and invaluable service to be offered in all community ADCs for the benefit of the older adult with SMI. She assumed participation in a music therapy group prior to beginning participation in a traditional ADC group activity might diminish the risk of non-adherence to treatment intervention. In her opinion, due to the multi-leveled barriers that occur as a result of stigmatization towards SMI, a successful integration experience might be more likely when individuals participate in a non-homogenous music therapy group. In this setting, the possibility to diminish social distance and enhance quality of life experiences are possible without the use of verbal intervention. This assumption stemmed from the author's clinical experiences with non-homogenous music therapy groups in community ADC's. She holds a strong belief that music and sound is a fundamental part of the human experience and of life. Within this assumption, it is the author`s opinion that music and sound puts the emphasis upon the participants' similarities, as opposed to drawing attention to their differences. As part of her personal and professional philosophy, the author believes music therapy can assist in diminishing the negative social perceptions held by some individuals towards SMI. The author assumed the possibility that participants within a non-homogeneous music therapy group might be able to experience, and thereby recognize the similarities they share pertaining to their psycho-social and interpersonal needs. In so doing, perhaps it would be possible for those with SMI and those without SMI to develop homogeneous awareness both in and out of the music therapy setting. Finally, the author assumed that when successful integration occurs in the ADC, outcomes include improved maintenance of health care, adherence to treatment, decreased hospitalization or re-hospitalization, improved quality of life, social functioning, and well-being.

Delimitations

This study was limited to considering the older adult, 65-years and older, with diagnoses of: Schizophrenia, Schizotypal, Borderline, or Obsessive-Compulsive Personality Disorder. For the purpose of this inquiry these diagnoses were designated (SMI) for ease of reading. The focus was delimited to Adult Day Centers that serve as a community health care service resource. Other mental health illnesses were excluded from this study since Schizophrenia, Schizotypal, Borderline, and Obsessive-Compulsive disorders have been, in the author's clinical experience, at higher risk for non-adherence to ADC participation as well as at higher risk for non-successful integration into an ADC. The reviewed literature was delimited to include publications from January 2000 to December 2015. Date exceptions were permitted when the information was of particular significance to the study. The period was chosen to provide an overarching and continuum of studies to effectively address the topic and targeted population.

Data Collection

An electronic search of the of the *Canadian Journal of Music Therapy,* the *Journal of Music Therapy, Music Therapy Perspectives,* the *British Journal of Music Therapy,* and the *Australian Journal of Music Therapy* was implemented using the keywords: "music therapy," "adult day centers," "psychogeriatrics," and "integration". A significant gap in the online literature was discovered in that only one relevant article was retrieved, therefore the online search was expanded to include journals and articles outside the field of music therapy. These included journals related to creative arts therapies, nursing, psychology, and psychiatry. Additional keywords were added to include "serious mental illness," "serious mental illness and music therapy," "psychiatric illness," "schizophrenia," "border-line personality disorder," "obsessive-compulsive disorder," "bi-polar disorder" with each category being linked to searches that included music therapy and adult day centers. Information was also retrieved using the following databases: ERIC, PubMed, Cochrane Database of Systematic Reviews, MEDLINE, PsychARTICLES, psychINFO, SAGE, ProQuest, Taylor and Francis, and Google Scholar. As the search progressed, web-based articles, government reports, unpublished master's, and doctoral theses, and a few scholarly books were also included due to the limited availability of peer-reviewed literature.

Data Analysis

Relevant articles were either printed to hard copy or saved upon a USB key, and backed up to Dropbox. The author chose to keep hard copies in binders rather than use a software program for ease of portability and access throughout the research process. In the first review, 63 articles were read, printed, and placed in one of two binders labeled, "Yes" or "No"; 60 articles were placed into the "Yes" binder, indicating the information was pertinent to the study. Three articles were rejected and placed in the "No" binder indicating the article was not applicable to the current study. For the second review, the journals, articles, reports, and thesis were re-read. An additional search produced another 20 articles and journal entries for a total of 90 readings. The author used a qualitative data analysis method, open and axial coding (Marshall & Rossman, 2011), to organize the data (i.e., information extracted from the sources) so that an informed argument could be constructed to address the research question. The data was logged using headers as the themes and categories surfaced. A pegboard was used to provide a large visual matrix for quick reference for the author. She also used analytic memos/writing to identify links among the themes, and to develop clusters of sub-categories for further analysis. This process also resulted in the manifestation of future research questions, as well as identification of a significant gap in literature.

Chapter 3. Results

Following the data analysis, the results were organized to link the reviewed literature with the themes and categories which had emerged. (See Appendix A and Appendix B). The author has attempted to organize the retrieved information in a manner that logically relates to one another to address the issues, concerns, barriers, and various viewpoints leading towards the development of the argument and discussion.

The Impact of the Aging Boomers Upon Health Care Community Services

As the "baby boomers" of today become the seniors of tomorrow, we can anticipate an increase in the demand upon ADCs to integrate these more serious forms of mental health illness into the community health care arenas. Since the deinstitutionalization of mental health care services, and with psychiatric institutions more commonly transferring those needing SMI services into non-psychiatric ADC environments, the need to understand and adapt the methods and interventions of care giving increases.

Beginning approximately around the year 2010, the first wave of baby boomers began entering their senior years. Now, in the year 2016, as more and more baby boomers are needing health care services, the system must adapt its resources to accommodate the transition of the newly aging population's global and individual needs. According to the United States Census Bureau (2014), it is estimated by the year 2050 the projected number of adults 65-years and older will have doubled to approximately 83.7 million (or 1 in 5). In Quebec in 2001 the statistics indicated the estimated population of individuals 65 and over was 136, 919. By July 1st, 2016, the estimated statistics indicated the number had risen to 473,865 (Institut de la statistique Quebec, 2005). Statistics Canada predicts that by 2036, the number of Canadian seniors will be approximately between 10.4 million to 10.9 million, doubling the statistics of the 4.8 million estimated in 2010. In addition to that group, the number of individuals born with mental disabilities will also be growing older and in need of specialized care (Canadian Healthcare Association, 2012; Statistics Canada, 2011). When referring to these statistics, we can make the presumption with such an aging population presenting, the number of individuals diagnosed with SMI will increase as well, and these individuals will thereby find themselves coping with the added difficulties of dual diagnosis, missed diagnosis, age related organic illness, and comorbidity. According to the Kim Foundation's mental health statistics (2016) approximately

2.4 million American adults or about 1.1 percent of the population age 18 and older, in a given year, have schizophrenia. Approximately 2.2 million American adults 18 years and older or about 1.0 percent of the population in this age group, in a given year, have obsessive compulsive disorder. Although mental disorders are widespread within the population, the main concentration of this paper is a much smaller proportion of about 6 percent, or 1 in 17 who suffer from serious mental illness. Nearly half, or 45 percent of those with SMI, have criteria as per the American Diagnostic and Statistical Manual for two or more disorders with the severity strongly related to comorbidity. As the projected number of individuals entering the senior phase of their life is estimated to increase to 88.5 million by the year 2050, and the percentage of SMI also increases, the need to have appropriate and efficient health care services available will be essential. Logic would indicate not to wait for the future, but to act now towards implementing effective treatments for this population thereby diminishing or preventing the risk of ineffective integration into the community health care system.

Senior Health Care

In the modern world, geriatrics, or geriatric medicine, focuses upon the health care of an individual who is generally 65-years and older. However, in scholarly circles debates continue as to what is a true definition of the word “senior”. In the report entitled A *Portrait of Seniors in Canada: Introduction* (Statistics Canada, 2006) a senior citizen is considered to be an elderly person, especially a person over 65. This same source refers to an elderly persona as rather old and past middle age. Although these definitions are very precise, they are often taken for granted by society at large. Nonetheless, some individuals contest this definition emphatically due to the increased life expectancy now being about 80-years thereby making 65-years of age closer to middle age rather than to the senior time of life. Since the beginning of the Twenty-First Century many persons outlive 65-years of age, therefore it can no longer be considered as “old” (Posner, 1995). That said, most social institutions continue to recognize the definition of geriatric to be beginning at the age of 65 as it remains recognized as the normal age of retirement from the work force. Sixty-five is also the recognized age where individuals are entitled to receive full pension benefits in Canada, even if many people retire or receive full pension benefits from their former employers before that age (Statistics Canada, 2006). Individuals with SMI being 65-years or older and with a chronic form of mental health illness are also categorized as geriatric by definition. The difference lies in their healthcare needs are often significantly more complex (Statistics Canada, 2006). Bartels and Pratt (2009) project that the health care system over the next two decades "will witness an unprecedented increase in the population of older adults with serious mental illness" (p.1). Even with the important implications this will have upon the health care system, "the specific needs of older adults have received limited attention" (p.2). These specific needs include impaired psycho-social functioning, increased health care costs, premature institutionalization, increased hospitalizations, and poor physical and other health outcomes. For older adults with SMI, one might say the system is operating below an acceptable level of functional service.

Elisha, Castle, and Hocking (2006) write "the separation between clinical treatment services and psycho-social rehabilitation programs for people with mental illness has created a system that is fragmented and makes it easy for individuals to fall through the net" (p.281). The types of ADC under investigation are service providers for seniors wishing to participate in the therapeutic activities to maintain or enhance their health care needs, and to remain living within the community. These types of ADCs provide their interventions through the medium of group activities, by developing global and specific group objectives while still providing global and specific individual objectives. In this manner, the participant of an ADC is able to create, enhance, and maintain their well-being. The literature reviewed has established the mandate of an ADC as service centered, and providing individuals with incentives and objectives leading towards enhancing or maintaining their cognitive, motor, physical, and mental health illness.

Psychiatric Institutions and Community Service

According to the L'Institut universitaire en santé mentale de Québec, (2009) since the deinstitutionalization of asylums and the rise of psychopharmacology in the 1950's and 1960's, psychiatric health care services have experienced great change. With the intervention of the Human Rights Commission, whose aim was to give an air of respectability to psychiatric institutions, mental health care changed dramatically. During this time, one of the new approaches applied was that of "open doors". This policy was designed to break up hospital stays for its patients by providing accessibility to walks in the parks, outings, and weekends spent at home to improve the quality of life for individuals with mental illness (IUSMQ). Diane Ballon (2011) writes with reference to the deinstitutionalization process beginning in Ontario, Canada "sixty years ago, mental health "patients" were being warehoused in asylums, with no voice to express their own thoughts and feelings, no safe space, no belief in any kind of future" (p.17). It was equally notable that although the process of deinstitutionalization had begun, and the movement was underway to physically move people out of the hospital, attitudes towards mental health patients and approaches varied little. When addressing social attitudes towards mental health, Ballon wrote, "Mental health providers maintained an often patriarchal, controlling attitude still embedded in a medical approach to caring for the mentally ill" (p.18). These unchanging attitudes left consumers and their families understandably angry, frustrated and hurt for it meant instead of being respected as experts in their own care, they continued to be viewed as disabled and incompetent to work towards their own recovery. Stigmatization and bias continued outside of the asylums and penetrated into the community. In this manner history shows, although the doors were opened for integration to community, the social attitudes remained unchanged towards mental illness.

In 1961, the Quebec Liberal government formed a commission to study psychiatric hospitals with one of the recommendations being deinstitutionalization. The results of the study lead the Commission to become convinced hundreds of patients were living in in mental hospitals even though their actual mental state did not require hospitalization. Their report concluded with the following three main recommendations: 1) That mentally ill patients were to be treated in a location close to their residence to avoid social uprooting; 2) That smaller hospitals (500 beds) attached to regional general hospitals would be providing more adequate services; and 3) That each psychiatric hospital would have to provide a range of services which were outpatient clinics, day, and night centers and more (IUSMQ, 2009).

The Commission's report began the second phase of deinstitutionalization and in 1975 Quebec established three objectives. This inquiry addresses but one of the three; the establishment of a greater number of services in the community in order to avoid hospitalization in the psychiatric environment (IUSMQ, 2009). Community health care in Quebec continued to evolve moving towards functional rehabilitation and specialized services, one of which was considered a specialized intervention form for treating the elderly and called gerontopsychiatry (IUSMQ).

By 1976 the number of individuals with mental health illness living within psychiatric hospitals had decreased significantly, (from 66,000, after World War II, to 15,011). Despite the decrease in numbers, efforts made to address the rehabilitation process within the community proved to be unsuccessful, and particularly so for individuals with SMI. The Public Health Agency of Canada (2006) suggested this was due to fragmented and inadequate services. Individuals with SMI lacking the fundamental skills for survival outside the institutional setting quite simply began to "fall through the cracks" of health care (Public Health Agency of Canada, 2006). The second half of the 20th century became synonymous with changes in the way psychiatric care was organized in Quebec. Treatment services were now being offered through community resources so people with mental illness could better integrate into the community. For those not needing ongoing psychiatric, medical, or nursing care, the learning from specialized professionals in community service centers made it possible for patients to receive care better suited to their needs by providing education, learning, recreational, and motivational services. The objective, a successful return into society. The birth of the Adult Day Center had begun.

Serious Mental Illness

Serious mental illness may be defined as a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) currently diagnosable, or has been diagnosed within the past year. The National Institute of Mental Health (2014), explains an SMI to be a disorder of sufficient duration to meet the diagnostic criteria as specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The illness must result in serious functional impairment, which substantially interferes with, or limits one or more major life activity (Substance Abuse and Mental Health Services Administration, 2016).

A Personality disorder is a form of serious mental illness which affects the way the individual thinks and feels about themselves, and others. This means the individual's thought processes significantly and adversely affect how they function in many aspects of life (American Psychiatric Association, 2013). While describing quite well the symptoms of a personality disorder, this definition tends to overlook the personal, interpersonal, and the individual as a whole being so essential when considering the requirements towards healing or recovery.

Skodol (2002) recommends using a model of psycho-social rehabilitation/intervention in the treatment of functional impairment for individuals with a personality disorder. Skodol's philosophy lies in the belief that the best treatment for functional impairment is psycho-social rehabilitation, making it therefore essential the health care system become progressive in creating programs which address and provide for successful social and functional rehabilitation for the consumer   An ADC, being a community service provider, is very well situated to provide such services while aiding in overcoming the persistently present social barriers towards SMI.

Adult Day Center and Serious Mental Illness

An adult day center is community based service provider. Mostly in group settings, the programs are designed to meet the needs of the functionally and/or cognitively impaired older adult. Franko (2014) writes "the existence of Adult Day Centers is still a relatively new phenomenon" (p.3). According to the *Metlife National Study of Adult Day Services* (2010), the number of years adult day centers have been in operational existence range between 50 years to 1 year, or less. For individuals who are 65-years and over, and coping with SMI this stage of their lives may present them with the added challenges brought on by the onslaught of age-related organic illness, and/or other life changing events (Public Health Agency of Canada, 2006). Since the beginning of the deinstitutionalization of asylums, up to, and including present day, community based service providers continue to attempt to offer the possibility of avoiding hospitalization altogether by using maintenance and therapeutic programs within the entity known as an Adult Day Center (ADC).

Adult day centers in the psychiatric community may be quite varied in the populations they serve. For example, outpatient psychiatric ADCs provide health care services specifically oriented to the needs of individuals with SMI. In this setting, the specific goal is to diminish hospitalization or re-hospitalization. Marshall et al. (2011) completed a systematic review of the effectiveness of day care services for individuals with SMI with search criteria of: acute day hospitals versus admission; vocational rehabilitation; and day hospital versus outpatient care. Their results found acute day hospitals to be an attractive option in those situations where the demand for in-patient care was high, and where the facilities existed which would be suitable for conversion. They reported acute day hospitals proved to be a less attractive option when demand for in-patient care was low and/or where effective alternatives already existed. The conclusion of their study suggested that further research is required to examine how acute day hospital care can be most effectively integrated into a modern community-based psychiatric service.

In comparing the acute day hospital in Marshal et al., (2011) to a community based ADC we see a similarity in their mandate of service. Both are based upon maintaining and improving mental health with the objective being to prevent hospitalization and re-hospitalization. The resemblance of the community ADC and acute day hospital in Marshal et al. demonstrates an epistemological connection between their study and the current inquiry. When analyzing their study and the target population of this inquiry, the connection lies in the definition of an acute day care center and an ADC. For Marshal et al., an acute day care center is comparable to an acute day hospital, with structured support for patients with long-term SMI, who would otherwise be treated in an outpatient clinic. The two areas Marshal et al. assessed were: (a) the effectiveness of day treatment programs versus outpatient care for people with non-psychotic disorders, and (b) the effectiveness of day care centers versus outpatient care for people with severe long-term disorders. Their results indicated that day treatment programs were superior to continuing outpatient care in terms of improving psychiatric symptoms. However, there was no evidence suggesting day treatment programs proved to be better, or worse, than other outpatient care models in other clinical or social outcomes. Although Marshal et al. did not include older adults with SMI in their study, the results demonstrated the importance of accessible community resource services. For this reason, the author has chosen to make a theoretical link to highlight there is an important relationship and argument to be made for maintaining SMI community health care from the onslaught of SMI illness until the end of life, regardless of age. Their study supports the understanding that continuity of community care for SMI in an ADC is inclusive and should therefore be considered part of essential health care irrespective of the age of the participant.

Adult day centers in Quebec. The Minister of Quebec (2005) created a document entitled " *Les services destinés aux personnes en perte d'autonomie liée au vieillissement. Enjeux-perspectives-balises regionals."* This document defines and demarcates the working mandate of a Quebec ADC to be a resource offering individuals 65-years and older, living with loss of autonomy, the ability to access preventative, rehabilitative, and therapeutic day activities. In Franko's (2014) study, the definition of an ADC is slightly different than the Minster of Quebec's, with Franko's definition indicating that the ADC is designed to meet the needs of the functionally and/or cognitively impaired older adult. Both are highlighted as being community based, using group programs as the mode of intervention. The Minister of Quebec demarcates the objective of an ADC as to enable the client the ability to continue to live within the community and receive the necessary bio-psycho-social health care services.

To meet the admission criteria into an ADC in Quebec, the individual must present with one or more motor, cognitive, sensorial, or mental health incapacity. When addressing SMI, the Quebec mandate recognized forms of SMI qualifying for admission to be anxiety and depression (Minister of Quebec, 2005). Older adults presenting with other form or trait SMI diagnoses are granted admission upon on the requisite basis they also present one or more motor, cognitive, sensorial, or mental health incapacity, but do not present disruptive behaviors preventing group goal objectives to be obtained. The ADC mandate lists three global objectives considered to be essential for the participant: (a) to maintain or enhance bio-psycho-social well-being; (b) to maintain cognitive, physical, and motor capacities; and (c) to provide family support as necessary. The mandate also includes supporting social relationships between the service-user and their social network. Exclusion criteria addresses the types of behaviors where: (a) despite the applied interventions, the individual presents disruptive behavior(s) thereby preventing the possibility of group objectives to be obtained, or (b) demonstrates an increased risk to security of the participants (Minister of Quebec, 2005). The exclusion criteria, although specific in format, leaves the definition of disruptive behavior deficient in clarity and open to misperception.

Franko (2014) highlights the outcomes of ADC service intervention to be the client's psycho-social and physical functioning needs or issues which, in her opinion, stem from an elderly individual's greater dependence upon the environment and their human resource network such as family and friends. Although her study makes no specific mention to address or define the needs of the older adult with SMI, they face the same organic age-related illnesses and psycho-social needs as the non-SMI individual who finds themselves coping with depression or anxiety related diagnosis which also leads to the loss of autonomy from other organic illnesses. The Quebec ADC bases their intervention criteria upon losses of autonomy from physical and psychological illness (Minister of Quebec, 2005). This means the exclusion criteria into Quebec's ADC's in the greater urban areas represent a barrier to the integration process. During the pre-inscription phase, the individual seeking admission to an ADC with either an actual or socially perceived history of disruptive behavior stemming from the traits of SMI, may find their common SMI behaviors to be mistakenly identified as disruptive behavior. As disruptive behavior is considered criteria for exclusion the risk of exclusion or denial of admission registration is elevated. Elisha, Castle, and Hocking (2006) maintain that the health care system is fragmented. They suggest uphold the opinion although it be recognized this population require essential clinical and psycho-social services, with a non-fused health care system the risk of non-adherence to care increases. As the role of the Quebec ADC is to provide health care services and to decrease social isolation what then are these barriers to integration?

The Many Names and Faces of Stigma

Stigma continues to be one of the biggest barriers attached to mental illness and social integration (Baumann, 2007; Corrigan & Watson, 2002; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Fung, Tsang, & Corrigan, 2008; Griffiths, 2011; Hayward & Bright, 1997; Haghighat, 2001; Jackson, 2015; Jones, Farina, Miller, & Scott, 1984; Link & Phelan, 2001; Moran, 2009; Mental Health Canada, n.d.; Skodol et al. 2002; Snowdon, 2003; Thornicroft, Rose, & Kassam, 2007a,b; Watson & Corrigan, 2013). Ageism is an added factor in the issue of stigma, which, when combined with other barriers, places the older individual with SMI at critical risk for being overlooked for appropriate health care. Too often mental health problems are underestimated, misunderstood, under diagnosed, and untreated (Baumann, 2007; Riecher-Rossler et al., 2006; Sartorius & Schulze, 2005; World Psychiatric Association, 1998). Stigma is defined in many different ways but, generally speaking, is recognized to be attributed to feelings of being discredited or being seen as less than a whole person leaving the individual to feel tainted (Goffman 1963). With the general norm being conceptualized through the belief that one should behave in a particular manner under certain circumstances, stigmatization is seen as a characteristic that is contrary to the norms of social unit (Moran, 2009). Link and Phelan (2001) cited and placed significant importance upon the definition of stigma as found in Jones et al. (1984) naming stigma as a relationship between an attribute (mark) and a stereotype (undesirable characteristic). The mark that links a person to an undesirable characteristic is called stigma. To further delineate Link and Phelan added the additional component of discrimination to their definition.

Another face of stigma is known as the concept of being the “stranger”, and is attributed to those human beings suffering from, or labelled with, mental illness. These individuals may often become recognized within society as strangers, and become the members of the out-group, or society's outcasts. Upon being caste into the out-group, multiple barriers may be experienced thereby preventing the individual from finding their own adequate place within society (Baumann, 2007).

The social order is based upon norms, values, and expectations. To further clarify the individual who has been deemed the stranger is considered different from societal norms for the reason of presenting with unusual or abnormal behavior. When people observe these behaviors they may feel the desire to separate from the stranger (Baumann, 2007, Moran, 2009). When this occurs the form of stigmatization known as S*ocial Distance* is being applied. Baumann explains social distance as being either high or low with low social distance being characterized by feelings of commonality, versus high social distance being defined as "a strong aloofness, mostly connected by a diffuse fear" (p.132). Social distance creates a situation whereby, whether consciously or unconsciously, the individual with the unusual or abnormal behavior becomes viewed as the stranger within the community and may find themselves marked or discriminated against for no other reason than for being ill with a misunderstood or misdiagnosed illness.

Stereotype, prejudice, and discrimination are the three levels of psychological structures which encompass public stigma and self-stigma (Corrigan & Watson, 2002). Seemingly similar, it is important to comprehend the differences between each one and how they are individually defined. Public stigma is considered a stereotype which is a negative belief about a group (e.g., dangerousness, incompetence, character weakness) whereas self-stigma is the stereotype one gives to oneself thereby becoming negative belief about the self (e.g., character weakness, incompetence). Prejudice is an agreement with belief and/or negative emotional reaction (e.g., anger, fear) or an agreement with belief (e.g., low self-esteem, low self-efficacy). The last descriptor, discrimination, is defined as a behavior response to prejudice (Watson & Corrigan, 2013). This includes avoidance of work and housing opportunities, withholding help from the public's standpoint, and from the self-perspective. When understanding the impact of these structures we can begin to understand that discrimination stems from an individual's behavior response to prejudice thus leading to the afflicted individual failing in life's essentials, and essential moments towards an improved quality of life experience. Watson and Corrigan (2013) emphasize the need for education as a possible tool to overcome stigma, prejudice and discrimination and achieve the goal of demolishing the common myths surrounding SMI.

From the psychological view point, causes of stigma lie in the comparisons from which self-perception and the picture of reality of the world are constructed. For example, the stigmatizor benefits from the stigmatized by providing them with psychological dividends (Hiaghihat, 2001) thus creating an interesting and challenging dilemma within the community setting. To better understand stigma in this context, we refer to social distance. (Baumann, 2007; Steinbach, 2004) which lends a comprehensive explanation of how the other person is painted in a particular manner thus appearing as a stranger/outsider, or even as an enemy.

Haighihat (2001) reported individuals with SMI are acutely aware of the phenomenon of stigmatization. Bearing this in mind, it can be presumed individuals with SMI at some time in their life experienced some form of the phenomenon of stigmatization. With the information being revealed through the literature review can we , or should we, assume the *Us and Them* division may play an important role in causing the older adults with SMI to delay help-seeking, care-services, or perhaps increases the risk of non-adherence to antipsychotic medication which is very often a problem afflicting individuals coping with community psychiatry? Although Haighihat's study does not specifically address the target population of this inquiry, in the case of non-senior adults the literature leans towards a presumed response of yes.

The enormity of the problem pertaining to obstacles and blockages towards community services and social integration is well documented in peer-reviewed research articles on stigma; those most noted stem predominantly from psycho-social factors (Elisha, Castle & Hocking, 2006), bias (Snowden, 2003), negative attitudes (Thornicroft, Rose, & Kassam, 2007), and stigmatization (Crisp, 2000; Parliament of Canada, 2006). According to Weiss (2012) in his article published in *Disabled World*, stigma, ignorance, denial, and other factors affecting clients, family members, and professionals prevent treatment of an estimated 50% of mental disorders due to the individuals opting out of treatment/services due to stigmatization. Solli, Rolvsjord, and Borg (2013) explain that social stigmatization for SMI stems from the concept of mental health recovery as it existed in the 1960's and 1970's. This form of social stigma has its roots in, and is the response to, a long history of expert-led and deficit-oriented treatment, which took place "within huge psychiatric institutions" (p. 245) and in some forms continue today. Adding to this perception is the pessimistic expectation of recovery for those afflicted with SMI, and especially for those with schizophrenia, by both family and professional health care providers. Solli, Rolvsjord, and Borg (2013) explain that in the eyes of the community, long term hospitalization, deficits, and problems of the past remain the defining features of the individual's identity and interrelated stigmatization in the present.

Racial and ethnic disparities cannot be overlooked as part of the problem of discrimination, bias, and stigmatization. These problems are as widespread in the diagnosis and treatment of mental illness as they are in other areas of health care. Surgeon General, David Satcher (2001) issued the report *Race, Culture, Ethnicity, and Mental Health* (United States Department of Health and Human Services, 2001) in which he documented disparities in access and treatment leave too many minority individuals untreated or improperly treated. However, we must remain aware that racial and ethnic differences by themselves do not constitute bias. In a society, and an era, where political correctness reigns, there are critics who argue that responding to racial and ethnic differences is essential and thereby permits for the differences in race, culture, and ethnicity to be recognized as part of the design of individuality. In other words, to these critics, ignoring the essence of the differences is, in itself, a means to create or reflect a different kind of bias. Still other critics doubt the very existence of mental illness. These critics believe giving a labels of mental illness is simply part of the universal problems of everyday living (Snowdon, 2003). Given there are so many different philosophies pertaining to what is or what is not bias, it becomes essential that service-providers be aware of and open to discovering their own philosophical viewpoint and attitudes concerning disparity.

Disparity and gaps extend to the access of quality care services for the elderly in minority populations (Snowdon, 2003), and presumably this includes older individuals with SMI within the minority population. Snowdon observed adults of African American and Latino heritage, including the elderly, were less likely than Caucasians to receive antidepressant medication, selective serotonin reuptake inhibitors, and newer atypical antipsychotic medications. African Americans were more likely to be recipients of injectable antipsychotic medications, or, when prescribed psychotropic medications, the dosage was sometimes suspiciously high. Segal et al. (1996) reported African Americans seen in psychiatric emergency services and in-patient settings were prescribed higher doses of antipsychotic medications than those individuals of other populations indicating the presence of racial disparity is real and must be recognized to be overcome.

Snowdon's (2003) research indicated the barriers are multi-leveled for individuals of minority groups. To clearly identify the issue of biases and disparities, Snowdon brings the reader's attention to other outcomes once financial barriers (e.g. poverty, homelessness, or other financial impacts stemming on cultural, racial, ethnic, ageism, or mental health) have been removed from the picture. These other factors continue to play an important role in preventing minority individuals from seeking treatment. Among the chief factors are: (a) the lack of familiarity of mental-illness related concepts, (b) the preference for treating mental illness in their spiritual or other culturally sanctioned terms, (c) stigma, and (d) coping habits that stress self-reliance and family reliance without pharmacology or other intervention modalities. Snowdon also refers to the terms overpathologizing bias and minimizing bias to provide further clarification on how bias and disparities may present. Overpathologizing bias occurs when unfamiliar, minority based behavior is interpreted as a manifestation of mental illness. Minimizing bias occurs when practitioners ignore genuine manifestations of mental illness, attributing genuine symptoms to variations in cultural beliefs and practices. Assumptions from this bias are that these perceptions are not due to actual differences between genders, age groups, or racial/ethnic groups, but are attributed to error on the part of practitioners. Both these definitions put into question the therapists' judgments and impact upon diagnosis/treatment protocols. Therefore, it is important to take into consideration that the broadening of the definition of bias is not without its limitations, but that the problem of overpathologizing or minimizing bias pertains to the directionality of the biased judgment, and can have direct impact upon outcome for the individual affected.

Upon this understanding, if judgment by some professionals is found to be biased, in any form, it is possible to assume that a cause and effect relationship stemming from the professional bias may also intrude on the potential of the formation of a healthy or positive clinical relationship. This could possibly lead to an elevated risk towards a compromised alliance, a lack of commitment to the client, or the occurrence of outright rejection. Therefore, when tackling the issue of bias within minority groups, the realization towards potential alienation, lack of trust, are, at times, compounded by cultural misunderstanding that cannot be overlooked or underestimated (Snowdon, 2003; Sue et al., 1991).

Snowdon (2003) addresses how bias occurs in the treatment of mental health through the beliefs and actions of individual clinicians, within organizational culture, and in the forms of intentional, inadvertent, and or even well-intentioned bias. From this perspective, Snowdon's study suggests bias to involve unfounded assumptions, which have become the normative beliefs shared by members of practitioner networks or treatment organizations. This means when addressing mental health care, the risk of being a victim to bias occurs when the people in position of authority, or average community members, become particularly intolerant to individuals with mental illness. When this happens we can say bias is present.

In his conclusion, Snowdon (2003) reported the notion that bias, whether intentional, inadvertent, or of a well-intentioned sort, exists. Because bias exists, the extent to which it operates within mental health care must be assessed. Once this is known, then perhaps it will be possible to develop effective means of addressing bias in all its many forms. Still, Snowdon's study indicated that professional bias is a very real problem effecting access to essential care and services.

When discussing bias, and speaking of organizational culture, we are referring to shared and often unspoken understandings about procedures and goals. Some of these shared understandings may include biases about mental health status, treatment, or social expectations. It is also possible that shared understandings may be expressed through neglect of the individual with SMI. Therefore, this author believes we must take into consideration that positive community engagement, or the concept of community engagement, should be considered one of the necessary norms of commitment to society towards essential health care.

Music Therapy

Music Therapy models all incorporate client-therapist alliance, musical experience, and the use of music to purposefully effect human behavior (Byers, 2012). Diverse methods of music therapy intervention may be used and are determined by the music therapist when assessing the most effective method to treat the client's needs. Byers writes: "music therapy is the varied way of working with music for purposes of improving the lives of people of varying needs" (p.244).

Of equal interest is the music therapist's method of practice as it reflects their philosophical approach (e.g., humanistic, psychotherapeutic, Nordoff-Robbins, client-centered, music-centered, etc.).

Music Therapy in an Adult Day Center

To develop the global treatment plan in an ADC, the first step generally begins at initial assessment with the multidisciplinary team and after a preliminary meeting with the client. Choices of group activities are presented to the potential participant and/or care-giver during the initial pre-admission visit. In the second step of the pre-admission process, the evaluator presents the preliminary client evaluation, which had been prepared and forwarded to the ADC via the CLSC, as well as the information received during the preliminary meeting and presents both to the multi-disciplinary team prior to accepting the request for admission. The preliminary evaluation assessment is called the ''Multiclientele Assessment Tool'' (OEMC) (which is the French acronym for "Outil d'évaluation multiclientèle" (Dubuc, et al., 2013). It includes medical, familial, and social information given in a one-time visit by a social worker, nurse, physiotherapist, or occupational therapist and used as the introduction profile of the client. No individual cannot request registration into the ADC without the OEMC having been completed. For this reason, during the pre-registration period, which includes the initial days of participation, a grace period of four to six weeks is suggested prior to the re-evaluation of objectives and/or the changing of group activities. At that time the ADC team will determine if the individual is integrating successfully into the preliminary group chosen or if a change into another activity is suggested. The true portrait of the individual takes time to present, unfortunately due to the pre-registration process the music therapist may, or may not be able to address the potentially multifaceted therapeutic needs often present in older adults with SMI at this crucial preliminary stage of integration.

Ultimately, the global goal of the ADC is to provide for a positive social experience by maintaining or enhancing quality of life for older adults and providing effective health care (Minister of Quebec, 2005). When music therapy as an intervention has utilized a music-centered, client-centered, or improvisation-centered method it has been reported to appear to enhance social rehabilitation for individuals coping with SMI in-hospital (Silverman, 2011a, b, & c). Exercising this assumption, might we argue that music therapy appears efficient in potentially meeting the needs of the older adult with SMI and respecting the group requirement and criteria of the ADC protocol? To further enlarge the suggestion, consider the potential for increased socialization should group music therapy enhance and aid in making cohesive inter-personal relationships within session setting. In this instance the goal of integration into the larger social ADC community, outside of the music therapy session, may also be enhanced. Assuming this occurs, is it equally conceivable an improved community experience outside the ADC could be an outcome result thereby leading to improved adherence to health care, to essential health care intervention, and to an efficacious quality of life experience? These responses could be measurable via testimony of the service-consumer who experiences decreased anxiety, increased socialization, and the maintaining or enhancing of motor and cognitive skills.

Other assumptions for music therapy include the belief that musicality is innate and essential to the human experience (Byers, 2012). Considering this assumption, music therapy can be purposefully used to affect change for the recipient. This raises the question: how can music therapy assist to impact change? To reply, we must look at the role of music therapy within the healthcare system and, for the purpose of this study, specifically in SMI.

Music Therapy and Quality of Life

Franko (2014) reports positive associations between social engagement and various aspects of the older individual's physical and cognitive health. Her research highlights the needs of this population and the importance placed upon social engagement in promoting and maintaining a healthy quality of life. Kamioka, et al. (2014) found that music therapy improved global and social functioning in schizophrenia and/or serious mental disorders. Research by Gold, Solli, Krüger, and Lie (2009) indicated global state, general and negative symptoms, as well as functioning improved significantly and by large effect sizes in those studies where a significant number of music therapy sessions were offered. A 10-week study by Grocke, Bloch, and Castle (2009) wrote of statistically significant improvement on five items of the *Quality of Life* (QoL) scale. Their results indicated: (a) music therapy was reported by the participants to give joy and pleasure, (b) working as a team was beneficial, and (c) participants were pleasantly surprised at their creativity. Jenson (2008) reported results showing that music therapy facilitated social inclusion when used as a part of service-users' experience in a recovery-oriented practice in mental health care, and with outpatient or community service. Their findings indicated that music therapy assisted in enabling the service-user to increase use of their strengths and motivation, thereby suggesting music therapy promotes the possibility of broadening and developing strengths and resources leading towards and outcome of positive self-regard.

Carolyn Kenny is a Professor Emerita at Antioch University. Practicing music therapy since 1969 and with many articles and some books on Music Therapy and Indigenous Studies to her credit, she describes her working philosophy as the “Field of Play”. In her opinion the “field of play” is a place where numerous potentials open up to the client and is revealed through the wholeness of their humanity (2006), with wholeness representing the individual. Her philosophy is one in which music therapy attempts to provide for and to enhance a musical experience free from stigma and limitations. The participating individual with SMI is permitted to become re-acquainted with their own identity. Kenny`s approach to music therapy has influenced this author’s humanistic working philosophy. When applying humanistic and global approaches with the older adult with SMI, she has clinically observed the positive outcomes within her music therapy sessions when the individual was experiencing an environment free from stigma and limitations due to their SMI diagnosis. In this manner, music is not a tool to be used, but an experience of interaction and of simply being human. While engaging in music, the individual with SMI is being invited into a shared human experience. When engaged in the music activity, basic human needs are being provided for by creating a sense of belonging, safety, and relationship. Here is experienced a space where strengths can be mobilized and utilized, a space which enhances functionality and addresses issues and limitations that exist in mental illness and may potentially lead to an enhanced quality of life experience (Jackson, 2015).

Carr, Odell-Miller, and Priebe (2013) describe the features of music therapy which may play an important role for enhancing Quality of Life to include: (a) the frequency of therapy, (b) active structured music making with verbal discussion, and (c) consistency of contact and boundaries with emphasis upon building a therapeutic relationship and building patient resources. Within this structure one can also find the increased responsibility for decision-making and using informed choice making within the music therapy environment. When these elements of rehabilitation are underlined within the music therapy setting the client is being offered hope as an essential ingredient within the psycho-social rehabilitation. Hope then offers the potential of a positive Quality of Life experience, also referred to as recovery (Gold, Heldal, Dahle & Wigram, 2005; Mossler, Chen, Heldal & Gold, 2011). In two Cochrane reviews of group music therapy in SMI, the results were collected and assessed by questionnaires and described in qualitative interviews, the results demonstrated music therapy can increase motivation, social functioning, and global state in persons with serious mental illness (Gold, et.al. 2005; Mossler, et al., 2011). These results indicate the potential of the power of hope enabled through music therapy as a method of recovery to enhance the quality of life experience.

Positive Psychology, Music Therapy, and SMI Recovery

According to Jackson (2015), music therapy is an intervention that naturally incorporates concepts of positive psychology interventions. For Jackson the relational quality of music therapy for chronic SMI may be one of the most unique and powerful features of music therapy. Jackson's study addressed the process of recovery for those diagnosed with SMI by reporting the stories and interviews obtained from individuals with SMI and how, through building relationships with peer groups and within the community, they have been able to develop hope, self-acceptance, self-responsibility, and self-efficacy as the vital parts of their recovery. When Jackson addresses stigma, she explains how the self-stigma and community stigma of SMI diagnoses can create a ''catch-22'' situation leading to mistrust, re-traumatization, grief and, loneliness for the individual with SMI. In addition, stigma may also develop a chasm between those experiencing the symptomatology and the community. However, when properly approached using positive psychology, interventions change can occur over time leading the individual with SMI to learn self-help, self-coping tools, and skills towards finding satisfaction in everyday living. This is the concept being called recovery. Jackson (2015) reported recovery stories from interviews with individuals diagnosed with SMI to reveal the importance of social support, personal empowerment, and a sense of independence while providing a positive outlook on both the present and the future. Additionally, building relationships within the community and with peer groups in a similar process of recovery has been directly related to higher self-esteem for individuals with SMI. When asking the question of how music therapy could be effective in the current provision of community health care we can look at how the emphasis is put upon recovery as the concept of hope, empowerment, and partnership (Chhina, 2004; Jacobson & Greenley, 2001). Chhina suggested these three concepts are strongly related to the overall goal of enabling individuals with mental illness to live successful and satisfying lives in the community through the assistance of diverse music therapy interventions.

Bradt, Dileo, Grocke, and Magill (2011) conducted a study involving 30 trials, which included music therapy interventions offered by trained music therapists in hospital settings. These included personally-tailored “live” music experiences using improvised or pre-recorded music, playing musical instruments, improvising music, and composing music providing patients with an aesthetic experience that seemed to offer comfort and peace during times of distress. The study illustrated that interactive music making within the music therapy setting, along with the music-client relationship, provided a deeply humanizing and validating experience for the clients. Silverman’s (2006) quantitative study reported that music therapy was rated the highest of three activity therapies by 27 patients in psychiatry. Is it possible then to begin to theorize that there is room for hope and recovery to manifest within the aesthetic experience of music therapy, if and when comfort and peace manifests as a result? Studies in dose-effect response may answer that question.

What does recovery mean for those with an SMI? Jacobson and Greenley (2001) focused upon a recovery-oriented model to address the needs of the individual, the health care system, and to advocate for change. Recovery-oriented models may be defined differently, dependent upon the venue in which they are being used; therefore, this author has chosen the definition used by Jacobson & Greenley due to its relationship with the criteria of this inquiry. In their view recovery is referring to both to internal and external conditions. The internal conditions includes the attitudes, experiences, and processes of change of the individuals who are recovering. The external conditions are the circumstances, events, policies, and practices that may facilitate recovery. When internal and external conditions are used together, they produce the process called recovery. This causes a reciprocal effect, meaning the process of recovery, once realized, can itself become a factor which further transforms both internal and external conditions. For those who describe themselves as being in recovery, the internal conditions being experienced are hope, healing, empowerment, and connection. The external conditions facilitating recovery are the implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services (Jacobson & Greenley, 2001).

Jacobson and Greenley (2001) discuss the role of the reciprocal relationship between the internal and the external conditions of recovery as implicit in the presentation of their model. This reciprocal relationship includes the possibility of having access to appropriate mental health services, providing consumers with the knowledge, skills, and strategies to assist with relieving symptoms, and learning how to control the effects of stress. When the possibility of developing collaborative relationships between providers and consumers exists, the likelihood of recovery increases. Jacobson and Greenley discuss the importance of having a collaborative relationship which will empower both involved parties. To achieve this entails both parties allowing for the meaningful development and implementation of power sharing, with an outcome of mutual distribution of responsibility. Emphasis here is placed upon peer support to enhance opportunities for bearing witness*,* a practice in which the opportunity allows the speaker, and the listeners, to establish new connections, and validates the idea that recovery is possible.

Jacobson and Greenley (2001) also speak of advocacy. In their opinion, reducing social stigma will in turn reduce the internalized stigma restricting some consumers the ability to define a self apart from their diagnosis. In other words, by advocating for the access to appropriate mental health services (including the access to education of mental health care service) consumers of these services will benefit from and be provided with the knowledge, skills, and strategies that relieve the symptoms and control the effects of stress. They suggest that when collaborative relationships become established between providers and consumers, both parties will be empowered. The shared empowerment will allow for meaningful power sharing and mutual assumption of responsibility. Through peer support, opportunities for bearing witness can then present themselves. Bearing witness is a practice allowing the speaker, and the listeners, to establish new connections thus validating the idea that recovery is possible. Similarly, as more consumers advocate and as the service consumer recovers, awareness and practice of recovery becomes more firmly entrenched into policy and practice. From this perspective, it is presumed that internal and external conditions will be transformed as a consequence (Jacobson & Greenley, 2001). This approach to recovery as a model appears to be ideal for integration or reintegration into community health care settings, and due to music therapy being presented in group settings in an ADC, the chance for shared empowerment might be enhanced. Unfortunately, however true this may be, Chhina (2004) points out that one of the most challenging obstacles practitioners in the field of psychiatry must overcome within the healthcare system is the health care system itself!

There is no single definition of the concept of recovery for people with mental health problems, and recovery does not always mean an individual will fully recuperate from a physical health problem; let us be reminded that the guiding principle is hope. With hope, the concept that it is possible for someone to regain a meaningful life, despite serious mental illness, can be considered part of the process of recovery (Mental Health Foundation, 2016).

Positive psychology literature suggests that addressing the issues of self-concept, self-efficacy, and of Quality of Life is integral to successful recovery from mental illness. Music therapy provides opportunities for individuals with SMI to address these types of subjective goals through musical engagement thus allowing them to be heard, to build relationships, and to re-experience the wholeness of their own humanity (Jackson, 2015). Jackson speaks of how the health care system focuses its attention upon the stabilization of active symptoms which are troublesome and/or injurious, potentially causing difficulty to the individual and/or to the community. She explains, although the need to stabilize symptoms is necessary, in order to have a successful return to community it is equally important to address those non-behavioral issues that tend to disrupt long-term stability. In her opinion, the impact of SMI touches every domain of the individual's life, with the results being a possible disruption of interpersonal relationships with family, friends, or potentially leaving the individual completely disconnected from other/all social support. She writes that "identity as it was known prior to the onslaught of the illness can be destroyed" (p.90) adding that equally important are the claims made by the afflicted individual as they regain stability awareness. This indicates as awareness of their losses become present, they may find themselves facing a new level of devastation to their perception of self, and therefore this insight should be considered a trauma experience. The theory behind Jackson's hypothesis is the individual re-experiences the trauma each time a reminder of the losses presents, (e.g., when coping with illness management or with interpersonal relationships such as attempting to integrate into a community setting). This means the individual may be experiencing re-traumatization on a regular, and possibly, daily basis. In this author's clinical experience, when working with individuals with borderline personality disorder, she has observed how this population may experience re-traumatization, and especially how it can substantially limit the progress/process of rehabilitation. The need for the afflicted individual to learn effective coping skills for use outside of a therapy session is imperative.

Addressing Bio-Psycho-Social Needs

Psycho-social skills. To ensure successful rehabilitation, learning coping skills in psycho-social functioning and how to employ these appropriate life skills, both in and outside of health care settings, is important. The studies used in this inquiry indicated music therapy has been used to effectively teach individuals with SMI about: (a) their illnesses, (b) their medications, (c) healthy coping techniques in varied situations, and (d) appropriate leisure skills for well-being, as well as to provide support or aid in developing and increasing personal insight and a means to address the importance of learning and setting socialization and communication goals (Chhina, 2004; Mossler et al., 2011; Solli, Rolvsjord, & Borg, 2013) These results were obtained using qualitative survey questionnaires. A few systematic reviews and meta-analysis have examined the effects of music therapy in the field of mental health (Maratos, Gold, Wang, & Crawford, 2008; Silverman, 2003; Vink, Bruinsma, & Scholten, 2003), from which were found promising results suggesting music therapy has a number of beneficial effects for this population when added to standard care. De L'Etoile (2002), Gold, Solli, Kruger, and Lie (2009) discuss the dose–effect relationship for those with schizophrenia in music therapy. Their studies suggested how global state, psycho-social functioning, and general and negative symptoms improved significantly, and at times by large effect sizes, when a sufficient number of sessions had been offered. Unfortunately, their review included only four studies thereby limiting results due to the very narrow inclusion criteria and to attrition. Their study indicates that higher dose-effect is correlated to greater opportunity for task success.

When examining the symptoms and quality of life experiences among individuals with schizophrenia who participated in their research the results of Ulrich et al. (2007) indicated music therapy reduced negative symptoms, improved interpersonal relationships, and improved patient's ability to adjust to social environments after their release from hospital.

The physical. In an effort to maintain global state in schizophrenia, music therapy is beneficial as relaxation, especially when considering organic wellbeing (Bloch & Reshef, 2010). When attempting to create change during the learning of coping skills, while using relaxation as the method, it is important to recognize the process of relaxation as being employed systematically. If relaxation is approached in this manner, Bloch and Reshef reported results indicating improved sleep quality and, with music as relaxation, the participants found the effects of the relaxation to be superior to muscle relaxation. This finding is important for individuals living with schizophrenia as insomnia is a commonly experienced feature which can lead to serious consequences for daytime functioning as well as diminishing the quality of life experience. Also included in their study was an unexpected result which directly links their study to this inquiry. The elderly participants in the study reported improved sleep efficiency which included fewer spontaneous arousals, improved functioning during the day, and an overall general feeling of well-being after listening to music.

As reported by Bloch and Reshef (2010), for individuals living with SMI, and particularly those with schizophrenia, experiencing appropriate sleep quality is imperative to good health. With as little as 30 minutes of music supported relaxation, sleep quality was enhanced. Music relaxation was also reported as being an enhancing tool, for sleep efficiency or as a coping skill, when anxiety needs to be controlled (Bloch & Reshef, 2010). The findings indicated that by playing relaxing music every evening for 1-week, at bedtime, for approximately 40 minutes, sleep quality was improved in patients/individuals with schizophrenia. The control used 7 days without treatment and 7 days with treatment with results indicating a decrease in depression, anxiety, tension, and distractibility. They concluded “music relaxation improves sleep quality and has the potential to ease schizophrenia symptoms and reduce levels of depression and anxiety for people living with schizophrenia” (Bloch et al., 2010, p.99). However, Bloch et al. (2010) showed no significant differences were indicated when measuring Quality of Life, as the ability to enjoy life, before or after music relaxation.

The results of this study prompt the question whether using music therapy to teach methods of relaxation, might provide the same, or similar results when utilized in an ADC, particularly for the older adult with SMI diagnoses of schizophrenia, borderline and/or obsessive-compulsive disorders to decrease insomnia.

The emotional. The Public Health Agency (2006) has identified social support as one of the 12 key determinants of health. Social support has a positive effect on both physical and mental health status as well as the potential to moderate the functional impacts of illness and disability in old age by providing a sense of control and purpose (Chhina, 2014) It is suggested that one of the pathways to motivation and engagement commonly involved in music therapy is mood alteration, and this may be a reason clients have a positive experience in music therapy (Markovich & Tatsumi, 2015). Individuals with schizophrenia have difficulty processing their emotions and identifying their feelings (van der Meer, Van't Wout, & Aleman, 2009) therefore, interventions specifically targeted at affect regulation and recognition of emotional state could promote emotional well-being in schizophrenia. As previously mentioned, individuals with schizophrenia have an inability to successfully recognize, express or manage their emotional state and Van der Meer et al. (2009) suggests considerable attention should be paid to the depressive mood of the client. According to, or depending upon the direction of the effect, by targeting this specific symptom it may lead to improved emotional and social functioning. In their opinion, the implementation of emotional focused therapy might prove beneficial for well-being in schizophrenia. Greenberg and Bolger (2001) have argued that helping these individuals become aware of and how to regulate emotional reactions might help in the process of change and coping. They propose that learning to manage negative stimuli may result in personal validation, decreasing stress and increasing social integration/relationships. In order to redefine self-stigma as a normal event to enhance coping, Kingdon and Turkington (1991) used a cognitive behavioral approach to diminish the impact. An outcome of their study resulted in the participants experiencing positive results. Unfortunately although subsequent studies delved deeper into the impact of similar cognitive therapies on psychotic symptoms, self-statements, and service utilization (Beck & Rector, 2000; Fung, Tsang, & Corrigan, 2008; Gould, Mueser, Bolton, Mays, & Goff, 2001; Turkington & Kingdon, 2000), very few other studies focused specifically upon self-stigma in the same manner as Kingdon and Turkington's (1991) study, leaving no further data to confirm or build upon their results. Still, according to Watson and Corrigan (2013), trends suggest that cognitive reframing may be offered as a useful tool for changing self-stigma basing their assumption upon the idea that self-stigma is weakened when people are educated to challenge their negative beliefs. Perhaps a music therapy-specific, cognitive-behavioral approach may prove to be an effective medium in assisting the target population achieve some form of emotional stability through improved emotional and social regulation.

Chapter 4: Summary and Discussion

The purpose of this study was to answer the question, “Might music therapy assist older adults with SMI successfully integrate/transition into a community ADC?” The literature retrieved was examined within five contexts: historical, clinical, psycho-social, philosophical, and theoretical. After analysis was completed the results were linked to develop the argument and present the conclusions in the following manner as demonstrated in the Summary of Results the Discussion, and the Conclusion.

Summary of the Results

Using constant comparative analysis, the themes were further examined and linked to develop clusters in the style of Patton (2002). Further analysis revealed the final themes and sub-themes (See Appendix A and Appendix B). A total of 344 patterns, thoughts, and themes were derived from the readings. The analysis of the open coding was reduced to 43 selective codes within 10 cluster categories: (a) Deinstitutionalization; 2) Adult Day Centers; 3) Geriatrics and Serious Mental Health; 4) Barriers to Transitioning and Integrating into a ADC; 5) Music Therapy; 6) Rehabilitation; 7) Recovery; 8) Coping; 9) Quality of Life; and 10) Argument/the pros-cons.

Analysis of the 10 initial cluster themes were further compared, categorized, sub-categorized and assigned the titles of: (a) Socialization, (b) Communication, (c) Music therapy, (d) Adult Day Center, (e) Problems specific to Serious Mental Illness, (f) Reasons for integration, (g) Interventions and Treatments, (h) Recovery, (i) Well-being, and (j) Barriers (See Appendix A).

Final analysis of the data resulted in the ten (10) categorized themes being further reduced to seven (7) final themes and given the headings of: (a) Socialization, (b) Serious Mental Illness, (c) Stigmatization, (d) Adult Day Centers, (e) Music Therapy, (f) Recovery, (g) Outcome. (See Appendix B) linking the themes together and upon which the development of the argument was based.

Three significant themes surfaced as predominant problems heeding the integration process into the ADC: (a) isolation due to SMI, (b) Serious Mental Illness, and (c) social and professional stigmatization. Two resources surfaced indicating the opportunity of obtaining successful integration as: 1) the ADC, and 2) music therapy as a contributing component. Upon completion of the analysis, a third resource surfaced which the author designated as Resource Outcome. The linking of all themes and resources was titled Outcome.

Stigma presented as a key factor and feature throughout this inquiry. The literature review demonstrated that stigma may be found in instances of professional, social, and cultural forms often resulting in social exclusion and self-stigma (Baumann, 2007; Corrigan & Watson, 2002; Crisp, 2000; Elisha, Castle & Hocking, 2006; Hiaghihat, 2001; Kingdon & Turkington, 1991; Parliament of Canada, 2006; Thornicroft, Rose, & Kassam, 2007; Watson & Corrigan, 2013; Weiss, 2012). Individuals with SMI often lack effective and adequate education in coping skills and social functioning, which can lead to isolation, non-adherence or dropping-out of therapy (Johannson & Eklund, 2006). It can also lead to the individual being excluded from or overlooked for services by professionals and care-givers whose formal training has been established to be deficient in effective mental health/illness education (Snowdon, 2003). The quantity of research literature upon the subject of stigma in general indicated the prevalence of professional bias within the healthcare system. Social perceptions stemming from misunderstanding the illness, lack of appropriate education, and misdiagnosis, both generally and specifically, towards the elderly with SMI plays a significant role in the risk of non-adherence to therapeutic intervention and participation in essential health care services. The resulting "dropping out" or lack of maintenance to essential needs and services increases the risk of re-hospitalization, or worse, elevates the risk of suicide Health Canada 2012; Johansson & Eklund, 2006; Hannibal et al., 2012; Mental Health Canada, 2016). The results indicated ADCs are a relatively new phenomenon in community care with its existence ranging between approximately 1 and 50 years. The types of ADC environment, staffing, costs, population requisites, and the models used for interventions vary from Canadian province to province, from United States state to state, and from country to country. The literature review provided insights into the various models used in ADCs. Some use a medical model, while others specialize in catering to specific populations, or needs such as physical rehabilitation or culturally-specific. Some are privately operated, while others are a part of the regional health care system, and thereby subjected to all government imposed restrictions.

Music therapy literature retrieved focuses predominantly upon adult individuals with schizophrenia or borderline personality disorder and not on seniors with SMI due to a significant gap in the literature reviews. (Bradt, Dileo, Grocke, & Magill, 2011; Grocke et al. 2014; Grocke, Bloch & Castle, 2009; Hannibal, Nygaard, Hestbaek, Egelund, Munk-Jorgensen, 2012; Silverman, 2011a, b, c, 2007, 2006, 2003; Silverman & Leonard, 2012; Solli, Rolvsjord & Borg, 2013; Talwar et al, 2006). The retrieved studies were conducted within psychiatric in-patient health care settings and psychiatric community settings. There was no specific mention of the senior individual with SMI as part of the population under study within the literature reviewed. The above-mentioned studies did provide significant peer-reviewed music therapy research upon user experiences of music therapy, dose-responses to music therapy, developing coping skills and learning how to use them in their daily lives: as a social recovery-oriented practice (Solli, Rolvsjord, & Borg); for social rehabilitation (Silverman, 2011 a, b, c,); for relaxation to improve sleep efficiency (Bloch, et al., 2010); and for improved quality of life (Grocke, Bloch, & Castle, 2009). The literature review demonstrated that music therapy has been used in psychiatric settings in order to teach patients about healthy coping and leisure skills, to support or aid in increasing personal insight, and as a method to increase successful social functioning (Tempier, Mercier, Leouffre, & Caron, 1997). According to Silverman (2006), music therapy programs are typically rated highly by psychiatric patients when compared to other psychoeducational programming and various types of traditional and alternative therapies. Systematic reviews and meta-analyses have examined the effects of music therapy in the field of mental health with promising results (Maratos, Gold, Wang, & Crawford, 2008; Silverman, 2003; Vink, Birks, Bruinsma, & Scholten, 2003). A Cochrane review for psychotic disorders (Gold, Heldal, Dahle, & Wigram, 2005) suggested that music therapy has a number of beneficial effects for this population when added to standard care. Through the review the author discovered that in Denmark music therapy is most frequently used in the treatment of patients with schizophrenia and personality disorders with results indicating music therapy affects global state, general and negative symptoms, depression, anxiety, functioning and musical engagement most effectively after 16-51 sessions (Hannibal, Pedesen, Hestbaek, Sorensen, & Munk-Jorgensen, 2012). Gold, Solli, Kruger, and Lie (2009) reported similar findings with ninety percent adherence for individuals with schizophrenia, and eighty-two percent for individuals with personality disorders remaining in treatment. Even with such high results, the variable that the author feels must be taken into consideration is whether the high adherence rate was specifically due to the music therapy, or was the variable the music therapist? Johansson and Eklund (2006) identified the factors related to interpersonal processes, and establishing alliance, can predict adherence or dropout, which confirmed for this author the importance of developing a therapeutic alliance as quickly as possible in the integration process into an ADC to obtain a successful outcome.

Discussion

Watson and Corrigan (2013) suggested that the link of non-adherence, or non-engagement, in mental health treatment is directly linked to the associated stigma and negative stereotyping. They reported that the fear behind many people choosing not to pursue mental health services is due to the risk of being labeled, or stereotyped, as a “mental patient” accompanied by the associated suffering, associated prejudice, and discrimination this label entails. In their opinion, the concept of stereotypes should be based upon the social concepts wherever efficient knowledge structures govern the understanding of a social group. These social beliefs are the sets of ideals and world views where groups within a community identify themselves. They appear to be coherent from the inside and if accepted, appear to be true. The opposite also applies, if they seem wrong, they are dismissed. Shortell (n.d.) calls this *common conscience*. The following example is used to demonstrate what efficient knowledge structure within society implies: “all police officers are good people to seek out when you are in trouble” (Watson & Corrigan, 2013, p.5). They also suggested that as the general population becomes more informed and leans towards understanding the theoretical structures which cause stereotypes, the chance of designing strategies also increases leaning towards the intention of reducing stigma, improving access to care, and assisting the service consumer to move towards recovery.

Isolation appeared to be a crucial problem facing the older adult with SMI, and a primary motive for referral to an ADC. Isolation also presented as being the common denominator between the existence of the ADC and older adults with or without SMI seeking integration into this health care service community. The results of the inquiry indicated that the use of music therapy within in-patient or psychiatric settings showed positive results towards the diminishing of SMI symptoms, diminishing negative symptoms, aiding in developing positive psycho-social functioning, and improving global state (Gold, Solli, Kruger, & Lie, 2009; Grocke, Bloch &

Castle, 2009; Hannibal, Perdeson, Hestbaek, Sorensen, & Munk-Jorgenson, 2012; Solli, Rolvsjord, & Borg, 2013). The literature results concerning psychiatric in-patients' perception of music therapy and other psychoeducational programming indicated that fifty-seven percent of participants with schizophrenia considered music therapy a positive social experience that made available experiences of joy and pleasure into their lives. These same individuals placed music therapy statistically higher than verbal psycho-education and considered it their favorite class/therapy (Silverman, 2006). Socialization in an ADC is generally considered a goal; however, depending upon the case circumstances it may also be considered an intervention. When used as an intervention, socialization appeared to counteract the negative impact of isolation, thus suggesting socialization as intervention is a positive resource for this population. Music therapy presented as a positive resource towards recovery in social, physical, emotional, and spiritual domains in the lives of the users. Another primary problem interconnected with isolation is the overwhelming effects of stigma. In this inquiry, the literature review demonstrated that stigma can block integration and enhance isolation, for example when professional bias is interlinked with social bias. The literature suggested the problem may possibly be overcome with advocacy and education in a learned manner. The literature review clearly demonstrated the need for education in the field of SMI both socially and professionally. The author wishes, as part of this summary, to make reference to the Canadian Association for Music Therapy Code of Ethics (1999) to demonstrate the importance of procuring and advancing in competency when addressing the needs of a chosen population as demonstrated in Article II.6-7-8, the role of a music therapist includes being, up-to-date on new and relevant knowledge, research, techniques and models (p.9); IV.11-12, being ethically and culturally informed (p.19), and the five Principles and Values which advocates for promoting ethical practice, respect for society, and minimizing harm (p.2-3). She has made this reference as it has been reported in this study that there is a possibility professionals, caregivers, and other participants in an ADC may, inadvertently or intentionally, create an *Us and Them* division therefore, may this be a reminder of the continual need for professional reflection when working with this population.

Pleasure in the music therapy experience revealed itself as another theme. If pleasure is experienced as part of the initial integration treatment and intervention process into an ADC, might this enhance the possibility of adherence to treatment? Although the quantity of studies was limited, Bradt, Dileo, Grocke, and Magill (2011), and Silverman (2006) found their results and comments from participants pointed towards music therapy as a treatment and intervention to generally be a positive one. Although these two studies (Bradt, Dileo, Grock, & Magill; Silverman) involved in-patient settings, the author argues the principle might apply as well to older individuals with SMI in an ADC. This notion entails linking the concept of the pleasure experience in music therapy to enhance participation in music therapy and the ADC. This notion then links the dose-relationship of participation in music therapy within the ADC to adherence to treatment and recovery. In the music therapy experience, where the music is the common denominator, and where differences are embraced, can we then make the link that music and music therapy has the ability to enhance the development of interpersonal relationships with other participants within the music therapy setting? If yes, is it possible to make the assertion when elevating the occurrence of social engagement in the controlled environment of the music therapy group/experience, the opportunity for becoming part of the team is enhanced? Silverman (2006) indicated participants claimed they enjoyed music therapy over two other forms of psychoeducational intervention. Is it enough to assume from Silverman's study that the pleasure derived from the music therapy experience may be enough to support adherence to treatment? We cannot at this time answer emphatically, « yes », however, we can refer to Denmark's music therapy studies for insights. Gold et al., (2009) and Hannibal et al. (2012), indicated anxiety, depression, and other negative symptoms decreased and adherence to group treatment increased to 90% (schizophrenia) and 82% (borderline personality disorder). The reported percentages are high however, the study did pose the question whether the high adherence rate was specifically due to the music therapy intervention or the music therapist. Despite the uncertainty, they concluded that the factors related to interpersonal processes and establishing alliance had a direct impact and can predict adherence or dropping-out.

Should Music Therapy Be A First Line of Entry for SMI in an ADC?

The literature demonstrated the effectiveness of music therapy for social development, social inclusion, well-being, and in some cases improved quality of life, for individuals within in-patient settings, and psychiatric community settings. In-hospital stays are becoming increasingly shorter in duration and the goal is to return the consumers to community service centers as quickly as possible with a higher level of treatment compliance and of effective coping skills being realized (Silverman, 2011). In some instances, music therapy has been used as single-dose session with success towards this outcome. Silverman demonstrated that learning coping skills within in-patient settings when receiving music therapy produced effective results. Implying again the goal being for the client to return as quickly as possible back to using community services, it can be presumed the individuals' mental health status is considered stable enough, at that time, to make the transition back into community life. In this instance, when the individual with SMI is leaving the psychiatric setting, entering, or reentering, into an ADC, participating in a music therapy group upon entry can be presumed to facilitate the entry/re-entry process. This presumption stems from the literature where, in the eyes of the service users studied, music therapy is often not experienced as a treatment (therapy) intervention. The experience was described as pleasurable and easier to connect with due to its non-traditional creative process. The literature suggests music therapy may be considered proficient and accessible while providing pleasure, fun, and personal validation. All of which occur as the essential elements towards supporting adherence to therapy.

De L'Etoile (2002) describes three factors in determining the effectiveness of therapy as follows: psychiatric symptoms should be reduced, therapy should be perceived as helpful, and the likelihood of clients remaining in or returning to therapy should increase. Although the group under study was long-stay patients De L'Etoile concluded that music therapy with psychiatric patients was most effective in reducing anxiety related symptoms. Consequently, the author suggests using music as a therapeutic tool for older adults with SMI should be explored, particularly so within resource of an ADC for supporting the adherence to treatment.

In an attempt to eliminate stigma and prejudices at the time of ADC admission and to advocate for adherence to therapy, this author suggests that music therapy groups be considered as a first line of entry for those with SMI. The reasoning behind her suggestion stems from the opportunity group music therapy provides towards beginning a positive integration experience under the overarching group experience. In the music therapy group setting, the stranger becomes a part of the team, thereby reducing the risk of isolation and dropping-out of treatment. Their personal recovery needs are addressed under the music therapy umbrella while remaining a part of the team. As the social network begins to develop within the music therapy group, the possibility for validation, increased self-esteem, and social inclusion may become enhanced with hope as recovery. In time, this element of recovery could transfer to the overall community life within the ADC. As validation and inclusion increase, the client with SMI might successfully augment the rate of participation, which equates to increased dose-response within music therapy. The outcome results of this study indicate that music therapy intervention in an ADC may promote effective and sustained access to essential health care services when basing these outcomes upon the results retrieved in other in-hospital and psychiatric settings.

In the studies reviewed, open, closed, and control group studies occurred within a specific time frame. When considering music therapy interventions in an ADC, three question arise : (1) Should time limitations be considered and/or imposed to determine if the integration was successful (e.g., the number of weeks of a predetermined music therapy program may run from 12-weeks to 16-weeks and with re-evaluation following the seasons or other time conscious criteria of the individual ADC; (2) Should the music therapist maintain the same participants within the group once a pre-determined number of objective positive responses have been obtained and systematically maintain or modify the global and specific objectives as necessary to meet the global needs of the group? This decision may be determined based upon whether the music therapy group is being provided as a closed group (in-therapy), or as an open group (as therapy, or therapeutic); and (3) Is maintaining participation in the music therapy group the best option for the older adult with SMI to support well-being and recovery until integration is realized and ADC community socialization is established? The clinical observations of this author suggest all three options have their place. As every ADC is a unique entity, neither one nor the other should ever take precedence. Rather, they should be closely monitored and modified in consequence of the participant’s state of well-being. Further investigation is required to provide a clearer response, but the author suggests that all cases should be looked at individually.

Chhina (2004) believes in psycho-social rehabilitation through music therapy for individuals with SMI. Anthony, Rogers and Farkas (2003) maintain that psychiatric rehabilitation, at its most basic, attempts to help people determine, identify, prioritize, and achieve their goals. The challenge of this study has been to address and confirm whether it is possible to incorporate the values of hope, partnership, and empowerment while still remaining true to the clinical mandate of the ADC through the use of music therapy as a first line of entry.

The outcome results indicate hope, respect, dignity, self-determination, and empowerment of the whole person, and not the illness, dominate as effective tools when discussing issues surrounding the individual with SMI, as well as when promoting awareness to the plight of those with SMI.

Music therapy uses the philosophy of the whole person. When working with individuals with SMI in an ADC, and as Chhina (2004) believes, the use of a psycho-social person-centered approach facilitates the decision-making process towards the individual learning to make informed choices for themselves, towards promoting and recognizing individual rights and towards learning to assume responsibility in self-helping and coping throughout the decision-making process, is informal and participatory where the activities are designed to engage in real world tasks and relationships. Chhina suggested by using the person-centered model the challenges of systemic stigmatization, bias, and prejudices may be reduced, thereby, increasing the hope for recovery. She also reported this model moves well between hospital and community, clinic, and living. Presuming Chhina's person-centered model challenges systemic stigmatization, the author contends it is reasonable to suggest this model is equally-well situated to address the difficulties facing the older adult with SMI integrate into the social environment of an ADC. Upon the commencement of participation following initial registration, person-centered music therapy could be used as a first line introductory program. Presuming a successful engagement occurs permitting the possibility to diminish stigma and bias to be considered recovery, the ADC may then become implicated as representative of life in the external community at large. Chhina's model also discusses the necessity for the music therapist to be able to meet the need of the client effectively. To achieve this end it would be necessary to have the flexibility to move between the ranges of environments involved in assisting the individual with SMI develop an awareness of community resources. An example of this might be the creation of a community choir, in or outside of the ADC, or developing other community resources that will allow the SMI client to utilize the coping tools learned within the music therapy environment.

Limitations of the Study

The author began this study with an assumption that music therapy would assist individuals with SMI the integration into an ADC, thereby creating a bias. For this purpose the author chose, and used for the first time, a philosophical inquiry. As the study progressed, she became aware of her bias that music therapy is an effective intervention for older adults with SMI was limited to her experience of one ADC site. Another limitation is the possibility that some pertinent information may have been overlooked due to the time allotment for completion of this study which prevented a more expansive literature search. It would have been advantageous and informative to further analyze data from other peer-reviewed and professional literary sources such as books or book chapters however as this was not possible, therefore due to the limitations of this study this research cannot be generalized.

Conclusion

In an effort to enhance and maintain participation in an ADC, the literature suggested that music therapy can be utilized with the understanding that each individual with SMI, in a music therapy session, presents with a unique health issue, their own strengths and weaknesses, their own personhood. Of equal importance is the individuals' personal perception of the music for a successful outcome.

The music therapy setting is an environment where the playing field is leveled creating an environment where personal strengths can be enhanced and creativity is invited. Within this creative environment recovery and hope become synonymous and opportunities are made accessible to discover there are more similarities than differences within the human experience.

Although music therapy is not currently considered an essential service within the ADC setting, the literature review indicated music therapy to be valuable in providing positive and successful bio-psycho-social results. This inquiry has shown evidence related to how music therapy has successfully assisted in teaching life skills, developing coping skills, enhancing the sleep experience for both adults with schizophrenia and for the elderly. Music therapy has also been shown to be effective towards developing awareness of self-validation, and finally, decreasing stress.

The results indicated that the potential for a recovery experience is enhanced when the negative effects of isolation for individuals with SMI is decreased. The analysis provided a dual response, one subjective and one objective. This inquiry has provided literature which presents the potential impact of music therapy to decrease stigma, and to build or develop positive psycho-social functioning for the older adult with SMI in an ADC. Studies of in-patient, and in-hospital results, for adults with SMI were linked to demonstrate and compare the circumstances facing older adults with SMI participating in an ADC. Further research on this topic is required to determine if music therapy should be considered as an essential service in an ADC. The author addresses this last point as she feels to provide positive empirical validation would also provide a stronghold for advocacy towards instilling music therapy in all Quebec ADCs, especially at this time in history when the baby boomers are beginning to enter the ADC communities for health care. Nonetheless, the literature did provide sufficient studies in music therapy in adult SMI to be valuable in substantiating successful bio-socio-affective support using person-centered, music-centered, improvisation-centered, or other models of approach when utilized in in-patient, in-hospital interventions with individuals with SMI.

This inquiry provides significant resources for music therapists working in ADC's, or other community settings, to argue for music therapy as a means to enhance socialization, develop coping skills, provide hope and empowerment to the individual, use a whole-person-centered approach, and possibly have a positive dose-related affect for those living with SMI. The studies referenced suggest the viability of music therapy as an essential part of health care services. However, as a philosophical inquiry, this study represents a first step only, with further research required. Therefore, it is hoped this inquiry will be used as a reference for future researchers who are as equally passionate about the SMI population as this researcher continues to be.

Finally, this author maintains a strong conviction for the need of music therapy within ADCs, and advocates for music therapy as an essential service in ADCs. She believes that music therapists can develop, initiate, and provide music therapy as part of the maintenance plan of mental health care service for those whose voices are too often lost, spoken over, or simply not heard may begin to resonate. Sadly, the author recognizes that bias, prejudice, and discrimination may never be fully overcome, but all professionals need to be reminded there is no place for it within a community healthcare system. It is her hope that future research will include seniors with SMI as participants, in an effort to provide qualitative and quantitative research to answer many of the questions that arose during this study. She hopes this study has provided the reader with information to further educate and promote future studies. In so doing, decreasing stigma and increasing music therapy within the community setting may become an outcome result. For this purpose she has included some potential topics for future research. They are as follows: 1) Why should music therapy be considered as a first line of entry into an ADC for individuals with SMI to enhance the integration process?; 2) What types of music therapy interventions or methods, are best suited to provide a successful integration into an ADC for individuals with SMI? Why? How?; 3) What makes music therapy different, more effective, or less effective when used in an ADC?; 4) How can music therapists advocate for the elderly individual with SMI in community service providers?; 5) What is the ratio of adherence to the program or to dropping out of the program when music therapy is utilized directly in the ADC program?; and 6) In what manner do communities provide music therapy services for older adults with SMI? These questions have surfaced many times both before and during this inquiry.

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Appendix A Categories and Sub-Categories

Chart 1 demonstrates how the data derived from the literature review was organized after the initial Open and Selective Coding process was completed. The 10 cluster themes were distributed for the first analysis as seen below.

Chart 1-Coding: ***Categories and Sub-categories***

Category	Sub-Categories	Sub-Categories	Sub-Categories	Sub-Categories
(a) Socialization	-Integration -Breaking the isolation -Coping skills -The need for developing social relationships -To be part of a team -Hope/Respect/Dignity	-To maintain treatment within a community setting -The role of music therapy in the SMI community -Regaining the sense of Self/Personhood	-Music Therapy models used in an ADC -Why music therapy is different from other interventions models	-Statistics-
(b) Communication	Socialization/breaking the isolation -Why the need for developing social relationships? -Integration -Being part of a team -Hope/Respect/Dignity	-The role of music therapy in the SMI community	Why is music therapy different from other interventions	
(c) Music Therapy	-Developing coping skills -Enhancing QoL	-Intervention and Treatments -Aids in sleep related issues -The role of music therapy in community settings	-Specialized Professional Service -Music therapy models and techniques used in and ADC -QoL: How it is defined & obtaining positive results	

Coding p.2				
Category	**Sub-Category**	**Sub-Category**	**Sub-Category**	**Sub-Category**
(d) Adult Day Center	-Health Issues -Age-related health issues, (Motor & Cognitive) Anxiety & depression	-A community service -Pros & cons of the environment -Psycho-social-bio rehabilitation -Cultural competency -Professional Ethics	-Barriers to Integration into and within the ADC towards SMI -Obtaining QoL- How it is defined and what is needed to obtain positive results	-Specific characteristics of ADC -Admission and exclusion criteria -Criteria of SMI in and ADC -Mandate -Older adults
(e) Problems Specific to Serious Mental Illness	-Music Therapy to reduce SMI symptoms -Difficulties presenting in reducing health care risks for older adults with SMI, or SMI population in general Music therapy to diminish negative symptoms -Developing social awareness	-Seniors & geriatrics -Psychogeriatrics -Co-morbidity -Suicide -Recovery in SMI (defined) Well-being (defined) -Relaxation	-Personality traits common or found in SMI -Impaired global functioning -Impaired social functioning -Co-morbidity components more difficult to address in SMI diagnosis and especially in psychogeriatrics. -Secondary effects and health care risks in SMI -Social behaviors in SMI	-Refining SMI for this inquiry -Developing pros & cons of argument

Coding p.3				
Category	**Sub-Category**	**Sub-Category**	**Sub-Category**	**Sub-Category**
			The role of relaxation in SMI and older adults	
(f) Reasons for Integration Into an ADC	-Enhancing, supporting the integration experience for maintaining essential health care -Breaking/diminishing the experience of isolation in the lives of older adults with SMI -Experiencing being a part of a team -Experience "pleasure" to enhance well-being and recovery Hope/Respect/Dignity -Regaining sense of self/personhood	-The need for inter/intra-personal experiences for well-being and recovery -Improved QoL experiences	-Diminishing negative symptoms -Music therapy has different models to provide for specific needs of interventions, ie: client-centered, music-centered. -The therapeutic Alliance	Developing and providing statistics to improve health care for SMI -Understanding social statements linked to SMI -Advocacy
(g)Interventions and Treatment	-Music therapy-Developing coping skills in/with/through music therapy	-Music/Sound -To assist in the global integration process into an ADC -To obtain & experience improved QoL using MT	Music Therapy models and techniques used in group settings in ADC -Role of music therapy in the community (SMI)	

Coding p.4				
Category	**Sub-Category**	**Sub-Category**	**Sub-Category**	**Sub-Category**
(h) Recovery	MT to reduce SMI symptoms -Hope-Respect-Dignity -Sense of regaining self/personhood	-The role of relaxation with music in SMI for recovery -Diminishing negative symptoms -The route to social awareness -The therapeutic alliance	-Defining recovery in SMI	-Investigating the definition of Recovery in SMI -What does recovery mean for the older adult with SMI?
(i) Well-Being	-Reducing SMI symptoms using music therapy as an intervention -The route to social awareness -Achieving Hope/Respect/Dignity -Achieving being part of a team -Achieving sense of self/personhood	-Experiencing recovery -Increased & enhanced social experience -Positive therapeutic Alliance	-What does well-being provide for the older adult with SMI?-What does relaxation with music provide as well-being for the older individual with SMI?	-Eliminating stigma/bias/prejudice
(j) Barriers	-Professional and societal Prejudice/bias/ stigmatization -Misinformed opinions in society -Us & Them division Negative-social statements linked to SMI -Cultural & historical fear & Misunderstanding	-Breaking the barriers with/in/through music therapy	-The integration process into and ADC	- The integration process via exclusion criteria-Need for education in understanding SMI -Developing cultural competency

Appendix B: Linking the Themes

Chart 2 demonstrates the reduction from 10 to 7 cluster themes with their assigned headings as used to link the date and develop the argument.

Chart 2*: Linking the themes to develop the argument*

The Themes	The Links
(a) **Theme 1: <u>Socialization</u>**	
	Breaking the isolation
	MT models and techniques
	MT to diminish SMI symptoms
	Why the need for social relationships
	Social statements
	Cultural and ethical competency in an ADC
	Barriers towards individuals with SMI
(b) **Theme 2: <u>Serious Mental Illness</u>**	
	Seniors/Geriatrics/Psychogeriatrics
	MT models & techniques
	MT to diminish SMI symptoms
	Related risks
	With or without co-morbidity
	Social behavior
	Coping skills
	The role of music therapy
	Diminishing negative symptoms
	The therapeutic alliance
	Psycho-social rehabilitation
	Ethics and culture
	SMI personality traits
	Barriers towards accessing health care in SMI
(c) **Theme 3: <u>Stigmatization</u>**	
	Reducing risks for SMI
	Bias, Prejudice, Stigma, Discrimination
	Cultural and Ethical Issues
	The perceptions of society
	Respect
	Cultural and ethical competency
	Barriers towards accessing health care and SMI

Chart 2*: Linking the themes to develop the argument*

(Cont. p.2.)

The Theme	The Links
(d) **Theme 4: <u>Adult Day Centers</u>**	Specialized health care resource for Senior
	Community service provider
	Global and social functioning
	MT to diminish SMI symptoms
	Suicide (prevention)
	Providing and accessing statistics
	The route to social awareness
	Being part of a team
	Therapeutic alliance
	Breaking isolation
	Cultural and ethical competency
	Reasons for integration, treatment, intervention
(e)Theme 5: <u>Music Therapy</u>	The role of music therapy in an ADC
	Integration/social recovery
	Why is music therapy different from other interventions?
	Being part of a team
	Psycho-social rehabilitation
	Relaxation
	Diminishing negative symptoms
	Route to social awareness
	Respect
	Therapeutic alliance
	Improving Quality of Life experience
(f) Theme 6: <u>Recovery</u>	Psycho-social rehabilitation by participating in music therapy
	Successful integration/social recovery through music therapy
	Sleep improvement for schizophrenia/ relaxation techniques
	Breaking the isolation in music therapy
	Music therapy to reduce SMI symptoms
	Treatment within and ADC
	Hope/Respect/Dignity/Well-being

Chart 2*: Linking the themes to develop the argument*	
(Cont. p.3)	
The Themes	**The Links**
	Part of a team
	Improving Quality of Life experiences
	Diminish the risk of suicide
(g) Theme 7: <u>Outcome</u>	
	Improved socialization experience in an ADC
	Improved global and social functioning/being part of a team
	Integration
	Diminishing related risks
	Decreasing the risk of dropping out
	Recovery, well-Being, improved quality of life experiences
	Hope, respect, dignity, regaining sense of self-personhood
	Advocacy, changing perspectives towards SMI